

Newport News Public Schools
Permission for Emergency Care – HS Athletics

School _____ Grade _____
Student's Name _____ Birthday _____ Homeroom _____
Parent's Name _____ Address _____
Home Phone Number _____ Work Number _____ Cell Number _____
Allergic to medication (specify type) _____
Has student been prescribed an inhaler / epipen? _____ Is student presently taking medication? _____
If so, what type? _____ Does the student wear contact lenses? _____
Please list date of last tetanus shot _____
Any other medical problems _____
Insurance in addition to athletic insurance Yes _____ (complete other side of this form)

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home Phone Number _____ Work and/or Cell Number _____
Family Physician _____ Phone Number _____

In case of an emergency and I cannot be reached, the school has my permission to take my child to the emergency room of the nearest hospital and the hospital and its medical staff has my permission to provide treatment which a physician deems necessary for the well-being of my child.

Parent's Signature _____ Date _____

ATHLETIC INSURANCE INFORMATION

Student's Full Name _____
Name of Parent Who Carries Insurance _____
Name of Insurance Company _____
Policy Number _____

I certify that the above named student athlete has the above health and accident insurance coverage in addition to the Newport News Public Schools athletic accidental medical coverage.

Parent's Signature _____ Date _____