Newport News Public Schools
Permission for Emergency Care – 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 bottom section of this form)

IN CASE OF EMERGENCY, CONTACT

Name ____Relationship ______________________________

Home Phone Number ________________ Work Number ____________ 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

Revised 7/23