

**TRI COUNTY PUBLIC SCHOOLS  
STUDENT PROFILE / EMERGENCY MEDICAL AUTHORIZATION**

Please Print:

Student Name \_\_\_\_\_ Grade: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Student Date of Birth: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Daytime Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Daytime Phone: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Mother's Home Phone: \_\_\_\_\_

Guardianship: \_\_\_\_\_

May we contact you by email? If so, please write **guardian's** Email address:  
\_\_\_\_\_

Siblings Full Name(s) and grade that attend Tri County Public schools:  
\_\_\_\_\_  
\_\_\_\_\_

If this information should change throughout the year, please notify the High School office. Thank you for your assistance.

**Current Medication(s):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Food Allergies:** \_\_\_\_\_

**Allergies to Drugs:** \_\_\_\_\_

**Date of Last Tetanus Shot:** \_\_\_\_\_ **Blood Type:** \_\_\_\_\_

Other information an emergency responder/coaches/sponsors should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Emergency Medical Authorization

Student Name \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_ Yes I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury resulting from his/ her athletic participation.

\_\_\_\_ No No, I do not want you contacting anyone until after notifying me.

We parent(s)/guardian(s) and student are aware the preparation for and participation in interscholastic athletics and extra circular activities involves many risks of serious and permanent injury to the student. We understand and acknowledge the danger of these severe injuries as inherent in physical activity which may involve vigorous physical contact.

We parent(s)/guardian(s) and student have completely read, fully understand the inherent risk of injury and hereby indicate our continued interest in participation.

**\*\*\* In the event the parents cannot be contacted, please contact:**

#1 Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

#2 Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

In case of an emergency, (preferred if choice is possible):

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_

\_\_\_\_\_  
Signed (Parent or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date