EMERGENCY MEDICAL TREATMENT

In the event of an injury/illness, I give my consent for emergency medical treatment of my child. This treatment must be deemed necessary by a Physician or other medical personnel designated by the Utica City School District.

Athlete's Name______________________________ Birthdate__________
Parent/Guardian home phone__________________ School______________
Parent/Guardian work phone__________________ Sport_______________
Parent/Guardian work phone__________________

Family Physician____________________________ Phone ______________
Insurance Co.______________________________ Policy Number___________
HMO Provider Phone ____________________ Group Number___________
Preferred hospital____

Emergency person to be contacted, if parents/guardians cannot be reached:
Name______________________________ Phone__________________

Parent/Guardian signature___________________________ Date__________