UTICA CITY SCHOOL DISTRICT
Medical Department
929 York Street
Utica, NY 13502

EMERGENCY MEDICAL TREATMENT

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

ATHLETE'S NAME:_____ SPORT_____

ATHLETE'S DATE OF BIRTH_____LAST PHYSICAL DATE_____

PARENT OR GUARDIAN'S NAME_____

HOME PHONE: _____ CELL PHONE_____

WORK PHONE_____

PHYSICIANS NAME_____ PHYSYCIAN'S PHONE_____

INSURANCE CARRIER_____ POLICY NUMBER_____

PREFERRED HOSPITAL_____

EMERGENCY CONTACT IF GUARDIAN CANNOT BE REACHED :

1) NAME_____ RELATIONSHIP_____

   PHONE NUMBER_____

2) NAME_____ RELATIONSHIP_____

   PHONE NUMBER_____

PARENT SIGNATURE:_____ DATE:_____