## 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	Number Cell Number		
Allergic to medication (specify type)				
Has student been prescribed an inhaler / E	piPen?Is stud	ent presently ta	aking medication?	
If so, what type?	Does t	he student wea	er contact lenses?	
Please list date of last tetanus shot				
Any other medical problems				
Insurance in addition to athletic insurance	Yes (c	omplete bottor	m section of this form)	
IN CAS	E OF EMERGENCY, CO	NTACT		
Name	Relationsl	Relationship		
Home Phone Number	Work Number	Work Number Cell Number		
Family Physician	Pł	Phone Number		
In case of an emergency and I cannot be the emergency room of the nearest hos to provide treatment which a physician Parent's Signature	spital and the hospital	and its medica	al staff has my permissior	
ATHLETI	C INSURANCE INFORM	MATION		
Student's Full Name				
Name of Parent Who Carries Insurance				
Name of Insurance Company				
Policy Number				
I certify that the above named student a in addition to the Newport News Public			<del>-</del>	
Parent's Signature		 Date		