Athletic Department
Emergency Information and Parent Consent

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured under the authority of North Idaho Christian School, when every effort has been made to contact the parents.

Player Name _____Birthdate _____ Age ____ Grade ___

Player Cell Phone _____ Player email _____

Parents or Guardians names _____

Parents email _____ Home Phone _____

Parents cell phone: Father _____Mother _____

Address _____ City _____ State ____ Zip _____

If parents cannot be reached please notify:

Name _____ Relation to child _____ Phone _____

Name _____ Relation to child _____ Phone _____

Family Doctor _____ Phone _____

Known Allergies _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me or my emergency contacts, the treatment necessary for the best interest of the above named student may be given.

Parent Signature _____ Date _____