

QACPS Athletic Team/Student Emergency Information

Sport:		
Name:	Date of Birth:	
First	Last	Middle
Address:		Home Telephone Number:
Cell Phone Number:	Email:	
Full Name of Parent or Guardian:		
Father's Occupation:	Business Phone:	
Mother's Occupation:	Business Phone:	
If Parents/Guardian cannot be contacted call:		Contact Number:
Name		
Preferred Hospital:		
Family Doctor:	Doctor's Phone Number:	
Insurance Information:	Policy#	

PLEASE LIST MEDICAL HISTORY, PREVIOUS INJURIES, ALLERGIES AND MEDICATION(S) ON REVERSE SIDE