East Hampton Public Schools

EMERGENCY TREATMENT CARD

This information will be released to the coach and emergency treatment personnel.

Student's Name: _____ **Date of Birth:** _____ **Sport:** _____

Home Address: _____

Father's Name: _____ **Work Phone:** _____ **Home Phone:** _____ **Cell:**_____

Mother's Name: _____ **Work Phone:** _____ **Home Phone:** _____ **Cell:**_____

Alternate Contact: _____ **Work Phone:** _____ **Home Phone:** _____ **Cell:**_____

Family Physician: _____ **Phone:** _____ **Preferred Hospital:** _____

Dentist: _____ **Phone:** _____

Medications Taken (home/school): _____ **Known Allergies:** _____

Known Physical/Medical Problems: _____

☐ **Check here and use other side for any additional information.**

I give permission to appropriate school staff or their designees to render emergency treatment associated with an injury and I agree to hold the East Hampton Board of Education, its employees and its agents harmless in the administration of such emergency medical assistance. In cases of acute emergencies, where neither parent/guardian nor the alternate emergency individual identified above may be reached, permission is granted for my son/daughter to be transported and treated at a local emergency medical center. If any of the above information changes, I will contact the school nurse immediately.

Parent/Guardian Signature: _____ **Date:** _____

East Hampton High School 365-4030 East Hampton Middle School 365-4060