

SPORT: \_\_\_\_\_

# Olympia School District

Athletic Medical Card 2015-16

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LAST NAME	FIRST NAME	BIRTHDATE	GRADE
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PARENT/LEGAL GUARDIAN'S NAME (Please Print)

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HOME ADDRESS	STREET	CITY	ZIP
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HOME PHONE	WORK PHONE	ALT PHONE	Email Address
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**ALTERNATE PERSON(S) TO BE NOTIFIED IN CASE OF EMERGENCY:**

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NAME	HOME PHONE	ALT PHONE	Email Address
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PHYSICIAN OF CHOICE	PHONE NUMBER
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PREFERRED HOSPITAL	PHONE NUMBER
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NAME OF INSURANCE COMPANY	ID NUMBER
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If the parent/legal guardian and authorized physician named above cannot be reached at the time of emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, do you authorize and direct the school authorities to send the above named student (properly accompanied) to the hospital or doctor most easily accessible?  YES  NO

Do you agree to be financially responsible for all expenses incurred for treatment under the circumstances described above?  YES  NO

If the answers to any of the above questions are NO, please explain what action you desire school authorities to take.

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List all allergies or other medical conditions the above named student has which first-aid/emergency personnel should be aware of (including head injuries and/or concussions).

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PARENT/LEGAL GUARDIAN'S SIGNATURE

DATE

Received By:

Date

Revised 4.30.12