

CECIL COUNTY PUBLIC SCHOOLS
ATHLETIC EMERGENCY MEDICAL TREATMENT CARD

Athlete's Name: _____ DOB: _____

Parent/Guardian Contact Information

Home Address _____ Home Phone #: _____

(No PO Boxes): _____ Cell / Pager #: _____

Male: _____ Relationship to student? _____ Work Phone #: _____

Female: _____ Relationship to student? _____ Work Phone #: _____

Emergency name and phone if Parent/Guardian cannot be reached:

Name: _____ Relationship to student _____ Phone: _____

Name: _____ Relationship to student _____ Phone: _____

Name: _____ Relationship to student _____ Phone: _____

Insurance/Doctor Information:

Doctor's Name: _____ Doctor's Phone #: _____

Dentist's Name: _____ Dentist's Phone #: _____

Insurance Company: _____ Group/Policy #: _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____

Please fold here

COMPLETE ALL INFORMATION

Allergies (include allergies to bee stings): _____

List of current medications: _____

Date of Last Tetanus Shot: _____

List significant medical history below.

Include specific medical conditions and treatments, surgery, fractures, concussions, etc.
