

Piedmont Middle School Athletic Department

Emergency Contact and Parent Consent

Students Name: _____ Birthdate: _____ Age: _____

Parents Name: _____ Home Phone: _____

Address: _____ City _____ Grade _____

Parent's cell phones: Father: _____ Mother: _____

In an emergency if parents cannot be reached, notify:

_____ 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, the treatment necessary for the best interest of the above named student may be given.

Parent signature: _____ Date: _____

Address: _____ Date: _____