Rockdale County Public Schools
RCPS

954 N. Main Street • Conyers, Georgia 30012 • 770.483.4713

Athletic Programs

Emergency Information & Consent

SECTION A | STUDENT INFORMATION [PRINT OR TYPE]

ATHLETE'S NAME

AGE | **DATE OF BIRTH** | **GRADE** | **SCHOOL YEAR**

PARENT / GUARDIAN NAME | **DAY PHONE:**

PRESENT HOME ADDRESS (street, city, zip) | **EVENING PHONE**

PERSON TO NOTIFY IN EVENT OF EMERGENCY | **RELATIONSHIP TO STUDENT** | **DAY PHONE:**

PRESENT HOME ADDRESS (street, city, zip) | **EVENING PHONE**

SECTION B | INSURANCE INFORMATION [PRINT OR TYPE]

NAME OF INSURED: | **NAME OF INSURANCE COMPANY:**

EMPLOYER OF INSURED: | **POLICY / GROUP NUMBER: (see attached copy)**

SECTION C | MEDICAL HISTORY [PRINT OR TYPE]

ATHLETE HEIGHT: | **ATHLETE WEIGHT:**

LIST CHRONIC ILLNESSES (asthma, diabetes, etc.) | **LIST SEASONAL OR FOOD ALLERGIES:**

LIST CHRONIC INJURY TENDENCIES (sprained ankle, etc.) | **ATHLETE WEARS PROTECTIVE BRACE (ankle, knee, elbow, etc.)**

CURRENT PRESCRIPTION MEDICATIONS | **CURRENT OVER-THE-COUNTER MEDICATIONS**

SECTION D | EMERGENCY CONSENT AUTHORIZATION

I, _____, am the parent/legal guardian of

_____, who attends _____.

I consent to my child's participation in the following sports:

_____ - _____ - _____ - _____ - _____.

In the event that hospital care is needed and time allows, I prefer my child be taken to _____(hospital).

In the event of an emergency that may arise from my child's participation in athletics, I hereby authorize the Certified Athletic Trainer (ATC) or athletic coaching staff of _____(school) to consent to any medical treatment, diagnosis, and/or hospital care by a physician licensed in this state.

Signature of Parent/Legal Guardian | **Date**