

**PROGRAM PARTICIPANT PARENT/GUARDIAN
EMERGENCY MEDICAL INFORMATION FORM**

PARENT/GUARDIAN: PLEASE COMPLETE AND RETURN TO: THE CITY OF ALBION RECREATION DEPT.
ALBION, MI 49224

NAME OF PARTICIPANT: _____ SPORT: _____

MALE: _____ FEMALE: _____ HEIGHT: _____ WEIGHT: _____ BIRTHDATE: _____

STREET ADDRESS: _____

CITY: _____ HOME PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

MEDICAL CONCERNS: _____

EMERGENCY CONTACT: _____ PHONE: _____

FATHER/GUARD : _____ MOTHER/GUARD : _____

ADDRESS: _____ ADDRESS: _____

EMPLOYER: _____ EMPLOYER: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ PHONE: _____

MEDICAL INSURANCE INFORMATION:

COMP. OR PLAN: _____ COMP. OR PLAN: _____

ADDRESS: _____ ADDRESS: _____

POLICY #: _____ POLICY #: _____

PHONE: _____ PHONE: _____

I/we authorize The City of Albion Recreation Department: team physician, athletic trainer, or coaches to administer emergency first aid treatment and secure medical and ambulance services in case a parent/guardian cannot be reached.

Parent/ Guardian Signature

Printed Name of Parent/Guardian

Date