PORT JERVIS CITY SCHOOL DISTRICT ATHLETIC DEPARTMENT

EMERGENCY CONTACT FORM

Name: _____ Male or Female: _____

School: _____ Grade (2023-2024): _____

Address: _____

Date of Birth: _____ Age: _____

Name of Father: _____ Phone: Home: _____ Cell: _____

Name of Mother: _____ Phone: Home: _____ Cell: _____

Work Phone Numbers: _____

Please list the name, address and telephone numbers of a close family friend or relative who lives in the local area who can be contacted in case of emergency:

Name: _____ Relationship: _____

Address: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Please List any Allergies: _____

Medical History: (please circle) ASTHMA CARDIAC DIABETES SEIZURES

Prescribed Medications:

_____

Use and/or carry an inhaler, nebulizer or epipen:

_____

Doctor: _____ Phone: _____

Eyeglasses: Shatterproof YES or NO Contact Lenses: YES or NO