SOUTH LYON COMMUNITY SCHOOLS
ATHLETIC PARTICIPANT EMERGENCY CONTACT FORM

Athlete Emergency Information

Athletes Full Name (First, Middle, Last): ______________________________________________________

Date of Birth: ________/________/________    Grade: _______________________________

Home Address: ________________________________________________________________________

City: _________________________________________ Zip Code: _____________________

Health Insurance Company: ______________________________ Policy Number: ________________

Family Doctor: ____________________________ Phone #: ___________________________

1. Parent / Guardian:

Home #: _______________________ Work #: _____________________ Cell #: __________________

2. Parent / Guardian:

Home #: _______________________ Work #: _____________________ Cell #: __________________

In case of emergency, if you are unable to reach a parent/guardian, please contact:

Name: ___________________________________________ Relation:__________________________

Home #: _______________________ Work #: _____________________ Cell #: __________________

Parent/ Guardian Consent to Treatment

I, ________________________________________________________________________________, the
undersigned parent/guardian of _______________________________________________________,
(NAME OF PARENT/GUARDIAN) a minor, do hereby authorize the South Lyon Community Schools athletic department director, coaches,
athletic trainer or other school representative on my behalf to consent to ANY medical treatment deemed
necessary by any licensed physician/surgeon in the event of illness or injury to the above-named minor.

This consent to treat is intended to cover any illness or injury sustained while participating in any school
athletic competition or practice, on or off campus, and while traveling to and from the event.

If, in the judgment of any representative of the school, the above named student needs immediate care
and/or treatment as a result of any injury or illness, I do hereby request, authorize and consent to such care
and treatment as may be given to said student by any physician, trainer, nurse, hospital, or school
representative, and I do hereby agree to indemnify and hold harmless the school and any school
representative from any claim by any person whomsoever on account of such care and treatment of said
student. I hereby authorize any hospital that has provided treatment to the above named student to
surrender custody of that student to the coach, athletic trainer, or other school representative upon
completion of treatment.

These authorizations shall remain effective until the end of the 20_____/20_____ school year

Parent / Guardian Signature                                         Date

__________________________________________________  __________________________

Signature of Student                                              Date

Revised 6/2008

PLEASE RETURN TO YOUR COACH. THIS FORM REMAINS WITH THEM.