

Last Name _____ Grade _____ Social Security # _____ ID # _____ Date _____ Sport _____

Plano ISD Student Athlete Emergency Card

Student's Legal Name _____ Last _____ First _____ Middle Initial _____ Familiar Name or Nickname _____

Address _____ Street _____ Apt. _____ City _____ Zip Code _____ Area Code _____ Home Phone _____

Birthdate _____ / _____ / _____ Grade _____ Male Female Race _____

IMPORTANT HEALTH INFORMATION: Please list health conditions, allergies (drug or food, etc.), daily medications and medical history.

PLEASE FURNISH THE FOLLOWING INFORMATION IN CASE OF ACCIDENT OR SUDDEN ILLNESS:

Father Name	Lives with Father <input type="checkbox"/>	Mother Name	Lives with Mother <input type="checkbox"/>	Step-Parent or Guardian Name	Lives with <input type="checkbox"/>
Employer _____		Employer _____		Employer _____	
Work Phone () _____		Work Phone () _____		Work Phone () _____	
Cell Phone () _____		Cell Phone () _____		Cell Phone () _____	
Pager () _____		Pager () _____		Pager () _____	
Email/Fax No. _____		Email/Fax No. _____		Email/Fax No. _____	
(Enter information below if different than student) Home Address _____ Phone () _____		(Enter information below if different than student) Home Address _____ Phone () _____		(Enter information below if different than student) Home Address _____ Phone () _____	

List TWO persons who will assume temporary care of your child if you cannot be contacted.

Name & Relationship _____	Phone () _____
Name & Relationship _____	Phone () _____

****PLEASE COMPLETE THE OTHER SIDE OF THIS FORM****

Physician and Insurance Information

Doctor	Phone	Name of Insured	Employer
Dentist	Phone	Insurance Company	Ins. Co. Phone
Hospital	Address	Group #	Policy #

I, the undersigned, do hereby authorize employees of Plano Independent School District to contact directly the persons and health care providers named on this card and do authorize the named physicians, clinics and/or hospitals to render such treatment as may be deemed necessary for the transportation and health care of said child. In the event the physicians, other persons named on this card, or parents cannot be contacted, the school employees are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. (Section 35.01, Texas Family Code). I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

I request that the physicians, dentists and staff of the medical facility perform any diagnostic procedures, treatment procedures, operative procedures, x-rays and anesthetics as may be necessary in the diagnosis and treatment of my child. I authorize the medical facility to dispose of any specimen or tissue taken from named person.

I certify I am a parent with legal control of the child, the child's legal guardian, or have other court ordered control of the child. I understand that I must notify Plano ISD in writing to change any information on this form or to revoke any consent given herein.

Printed Name of Parent/Guardian _____

Signature of Parent or Legal Guardian _____

Date _____

Printed Name of Student _____

Signature of Student (If 18 or more years of age) _____

Date _____

TO GIVE PERMISSION TO BE CONTACTED THROUGH E-MAIL, PLEASE PROVIDE EMAIL ADDRESSES BELOW:

E-mail for _____ is _____

E-mail for _____ is _____