

Trinity Lutheran Athletic Health Emergency Card - 2026-2027

Date of Birth _____

Home Phone (_____)_____

Name _____ Grade _____
Last First Middle I.

Address _____ City _____ Zip _____

Father's Name _____ Mother's Name _____

Place of Business _____ Place of Business _____

Business Phone _____ Business Phone _____

Cell Phone _____ Cell Phone _____

Email _____ Email _____

Name of a relative or friend (must be 18 years of age or older) to be called in case of emergency or illness when parents cannot be reached.

_____ Name	_____ Relationship	_____ Phone
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_____ Name	_____ Relationship	_____ Phone
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_____ Name	_____ Relationship	_____ Phone
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List any medications that your child is currently using (including EpiPen, inhaler, etc.)

Please list any special conditions of health (allergies, etc.)

If, in the judgment of the school authorities, emergency treatment is required, I authorize my child to be transported by ambulance to a hospital for treatment. I also understand that the ambulance does reserve the right to convey the patient to the nearest definitive care hospital or the hospital of their choice, should they deem it necessary. I hereby authorize the physician(s) at the hospital to give emergency treatment to my child.

Name _____ Relationship _____
(Please print)

Signature _____ Date _____
