

- Soccer Volleyball Basketball Cheer
 Baseball Track & Field Golf

Student Information:

Students Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Allergies and/or Drug Reactions: _____

Chronic Illnesses: _____

Regular Medications: _____

Any previous/ongoing health problems: _____

Date of Last Tetanus Immunization: _____

Other Pertinent Data: _____

Student's Physician's Name: _____

Physician's Phone Number: _____

Parent or Guardian's Address: _____

Parent or Guardian's Work Phone Number: _____

Parent or Guardian's Home Phone Number: _____

Each student who participates in CPCS Athletics must have an active medical Insurance policy. Please complete the following for your student:

Name of Insurance Company: _____

Policy or Group Number: _____ Subscriber Number: _____

Should your child require emergency treatment, is there a preferred clinic, hospital or doctor?

Name of Doctor	Address	Phone
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Name of Hospital or Clinic	Address	Phone
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Emergency Phone Numbers: (We MUST have at least one)

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____