# Streetsboro Jr. Rockets

## EMERGENCY CONTACT FORM

Last name of child _____First Name _____
Father's name _____ Mother's name _____
Child's address _____
Home phone # ____- _____ - _____ Cell Phone# ____- _____ - _____ belongs to_____
Emergency contact person _____relationship _____
Home phone # ____- _____ - _____ Cell phone # ____- _____ - _____

Physician's name _____phone # ____- _____ - _____
Address: (City) _____ (street name) _____

Hospital of choice _____ phone # ____- _____ - _____
Address: (City) _____ (street name) _____
Insurance Company Name _____ Below, fill in the numbers that apply
Policy# _____
Group # _____
ID # _____
Carried by _____

Does your child have any allergies? (If yes, please list} _____
This Allergic reaction is best treated by _____
Symptoms of a reaction are _____

Does your child have any medical conditions or medications we should be aware of? _____
_____

Is there any information you would like the coaching staff to be aware of? _____
_____

If all attempts to reach the above contact persons are not successful, I would like the following procedure to take place: _____
_____

I hereby give my permission for the Streetsboro Jr. Rocket Organization to follow the above procedure(s) for my child _____ if attempts to reach the emergency contacts are unsuccessful.

_____ _____
(Parent or guardian signature) (Date)

_____
(Parent or guardian print)