

**2009-2010 Lake Washington School District  
ATHLETICS EMERGENCY INFORMATION**

Student's name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (MI)

Parent/Guardian's name \_\_\_\_\_ Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Father's Contact Phone: \_\_\_\_\_ Mother's Contact Phone: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Two persons you recommend we call in the event you cannot be reached:

Name & Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name & Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Preference of Hospital: \_\_\_\_\_

Preference of Physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Tetanus Booster: \_\_\_\_\_ Allergies: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Lake Washington School District  
HEALTH HISTORY**

Student's name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (MI)

Parent/Guardian's name \_\_\_\_\_

Home Phone: \_\_\_\_\_ Father's Contact Phone: \_\_\_\_\_ Mother's Contact Phone: \_\_\_\_\_

Surgeries / Hospitalizations \_\_\_\_\_

Allergies (foods or medications) \_\_\_\_\_

Current medications \_\_\_\_\_

**HEALTH HISTORY (check all that apply to the student)**

Asthma \_\_\_\_\_ (Do you use an inhaler? Yes \_\_\_\_\_ No \_\_\_\_\_)

Concussion \_\_\_\_\_

Contact lenses \_\_\_\_\_

Neck or back surgery \_\_\_\_\_

Hernia \_\_\_\_\_

Hearing defect \_\_\_\_\_

Knocked unconscious \_\_\_\_\_

Epilepsy \_\_\_\_\_

Heart problems \_\_\_\_\_

False teeth or bridge \_\_\_\_\_

Convulsions \_\_\_\_\_

Dehydration problems \_\_\_\_\_

abnormal bleeding \_\_\_\_\_

Sprains / strains / fractures \_\_\_\_\_

Anything else? \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_