

MS/HS Football Participants CENTRAL AMBULANCE FORM

Name: _____ Date of Birth: _____

Doctor: _____ Grade: _____

Hospital: _____

List any allergies: _____

PERSON TO CONTACT IN AN EMERGENCY AND PHONE NUMBER

1) _____
Name Relationship Phone

2) _____
Name Relationship Phone

PLEASE FILL THIS OUT COMPLETELY AND RETURN TO THE SCHOOL OFFICE. THIS INFORMATION WILL BE KEPT CONFIDENTIAL, AND WILL ONLY BE USED BY THE CENTRAL AREA AMBULANCE IN AN EMERGENCY. THANK YOU!