

**Cambridge High School**  
**EMERGENCY CONTACT SHEET**  
**For**  
**ATHLETICS AND OTHER ACTIVITIES**

*Please detail any information that would be helpful in an emergency. Be specific describing how to reach you (i.e., if you are at work, list a department or extension where we can locate you.)*

STUDENT: \_\_\_\_\_ GR: 9 10 11 12  
(Last) (First) (Circle)

PARENT/GUARDIAN: \_\_\_\_\_  
(Father)

\_\_\_\_\_  
(Mother)

Who should we contact in the event of injury or illness? \_\_\_\_\_

Please list the name and telephone number of each contact in order of preference:

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

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

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

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preferred: \_\_\_\_\_

Medical History: (Note if your student is on any medications)

Please check if your child has any of the following health conditions:

\_\_\_\_\_ Allergies                      \_\_\_\_\_ Bee Sting Allergy                      \_\_\_\_\_ Hearing/Vision Loss

\_\_\_\_\_ Asthma                      \_\_\_\_\_ Diabetes                      \_\_\_\_\_ Seizure Disorder

\_\_\_\_\_ Orthopedic Issues                      \_\_\_\_\_ Heart Condition                      \_\_\_\_\_ Other, please describe

Comments: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**PARENT AUTHORIZATION FOR  
RELEASE OF HEALTH INFORMATION**

With the passage of the Federal Health Insurance Portability and Accountability Act (HIPPA) in 2003, Cambridge High School is required to obtain for each student athlete from the parent or legal guardian, or the student if 18 years or older, an authorization permitting:

1. The student to be treated by a licensed athletic trainer.  
(Contracted between CHS and Fort Atkinson Memorial Health Services)
2. The disclosure of information related to injuries and treatment between the licensed athletic trainer and the appropriate school district staff.

All records generated through these activities are the property of FAMHS and are subject to state and federal privacy regulations. Information disclosed to the school district or its employees will be the minimum necessary to meet the intended purpose.

I, \_\_\_\_\_ authorize treatment by a licensed  
(Parent/Guardian Signature)

athletic trainer for my son/daughter in the case of injury. In addition, I authorize that information regarding any treatment or injury of my son/daughter may be shared between the licensed athletic trainer any the appropriate school district staff when necessary.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date