LOS ANGELES COMMUNITY COLLEGE DISTRICT
EMERGENCY INFORMATION
East Los Angeles College

NAME: Last________________________First______________________ SID# ____________________ (Circle) FRESH SOPH

DATE OF BIRTH______________________ SEX _______ SPORT ____

PERMANENT ADDRESS ____ CITY ______________________ ZIP ____________

YOUR HOME PHONE NUMBER _(_______)________________________ / CELL PHONE _(_______)______________________

FATHER'S NAME _______________________ ADDRESS ______________________CITY__________STATE___ZIP________

HOME PHONE (______)___________________ WORK PHONE (______)_____________/ CELL PHONE ___________________

MOTHER'S NAME ________________________ ADDRESS _____________________CITY__________STATE___ZIP________

HOME PHONE (______)___________________ WORK PHONE (______)_____________/ CELL PHONE __________________

ANOTHER PERSON TO CONTACT ______________________________________ RELATIONSHIP ______________________

ADDRESS ____________________________CITY_______________STATE___ZIP____ PHONE (_____)___________________

YOUR MEDICAL INSURANCE COMPANY ____

ADDRESS ____ PHONE NUMBER _(_______)______________________

POLICY NO. / MEDICAL RECORD NO. _________________________ PLAN / GROUP NO. _____________________________

If you have Kaiser Permanente insurance, please enter your medical record number instead of a policy number.

IS THIS PLAN A/AN HMO ☐ PPO ☐ MAJOR MEDICAL ☐

ALLERGIES TO ANY MEDICATIONS, OR OTHER INFORMATION MEDICAL PERSONNEL SHOULD KNOW:
____

ATHLETE'S SIGNATURE: ____

IF ATHLETE IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THE FOLLOWING:

AUTHORIZATION TO CONSENT TO TREATMENT

(I) (We) the undersigned parent(s) to ______________________________________, do hereby authorize ______________________________________ as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 6910 of the California Family Code.

This authorization shall remain effective until __________________, 20_____ unless sooner revoked in writing delivered to said agent(s).

Dated: ________________________________ ____
Father

______________________________________ ____
Witness Mother

______________________________________ ____
Witness Legal Guardian

__________________________________ __________________________
Address Phone No.