

Please Print in Ink

Student's Last Name		First Name		Middle Name	
Home Telephone () <small>area</small>		Date of Birth Month/Day/Year / /		Grade	Sex
Father/Guardian		Employer		Work Address	
				Work Phone () <small>area</small>	
Mother/Guardian		Employer		Work Address	
				Work Phone () <small>area</small>	
List up to three (3) emergency contacts in the event your parents cannot be contacted..					
Name		Relationship		Work Telephone () <small>area</small>	Home Telephone () <small>area</small>
Name		Relationship		Work Telephone () <small>area</small>	Home Telephone () <small>area</small>
Name		Relationship		Work Telephone () <small>area</small>	Home Telephone () <small>area</small>
Athlete's health problem(s)		Medications used on a regular basis/special treatments needed.		Allergies (including medications)	
Interscholastic Athletic Team Emergency Card-Berkeley High School Berkeley Unified School District					

January 2002

All previous editions are obsolete

continued on other side

PARENT/GUARDIAN CONSENT			Athletic Program	School Year
I hereby give my consent for the named student to participate in the named interscholastic Athletic Program for the school year indicated at Berkeley High School and to go with a representative of the school on any off-campus trips related to participation in the interscholastic Athletic Program.				
Emergency Medical Authorization				
Physician's Name		Address		Telephone () <small>area</small>
Dentist's Name		Address		Telephone () <small>area</small>
Health Plan		Policy No./Record No.		
<p>I, the undersigned parent/guardian of the student (shown on the front of this card), a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care to be rendered under the general or special supervision and upon the advice of a physician, surgeon or dentist under the provisions of the Medicine Practice Act, or Dentist Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care but is given to provide authority and power for the physician/dentist to render care which in his/her best judgment may be deemed advisable. This authorization is given pursuant to the provisions of Sections 6900 through 6910 of the Family Code of California. It is the responsibility of the parent/guardian to immediately notify the school in writing of any changes in the information on this card.</p> <p style="text-align: center;">Insurance Information</p> <p>The Berkeley Unified School District (BUSD) carries limited, supplemental medical insurance for injuries that occur only from direct participation in school-sponsored supervised and CIF approved interscholastic athletics. The student insurance policy coverage which the BUSD carries is secondary to any other medical or dental insurance you may have for your child. If an injury occurs, all claims must be presented to your primary medical or dental insurance for payment. Any remaining unpaid balance should be submitted to Myers-Stevens for benefit payment consideration. The plan has a \$100 deductible and a maximum benefit of \$25,000. Additional health insurance is available for purchase. For a brochure and application, contact the school office (510) 644-6121, or call or write Myers-Stevens (800) 827-4695. For any additional questions regarding benefit information or exclusion limitations, please contact Myers-Stevens.</p>				
Parent/Guardian Signature				Date
Interscholastic Athletic Team Emergency Card - Berkeley High School Berkeley Unified School District				

White copy - Athletic Office

Yellow copy - Sport 1

Pink copy - Sport 2