AAU Club Volleyball Sports Medicine

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Parents Name(s): _____

Mothers Work # _____ Mothers Cell: _____

Fathers Work # _____ Fathers Cell: _____

Student Lives With: _____

Insurance Co: _____ Policy # _____ Group # _____

Emergency Contact: Name: _____ Phone # _____

Student's Physician _____ Phone # _____

Student's Dentist _____ Phone # _____

Student's Optometrist _____ Preferred Orthopedic Dr. _____

Does your child have any of the following conditions? If so please explain type of medical treatment: ◯ YES ◯ NO

Asthma _____

Diabetes _____

Food or Drug Allergy _____

Bee sting Allergy _____

Seizure Disorder _____

Other Chronic or recurrent condition _____

Presently taking Meds Name _____

Reason for taking above Meds _____

I give permission for the Coaches to administer the following medications to my child according to normal medication orders: ◯ YES ◯ NO

Acetaminophen *fever, headache, pain

Antacid tablets (upset stomach)

Ibuprofen (cramps, muscular/skeletal pain & inflammation, severe headache)

Parents and/or Legal guardian's signature: _____ Date: _____

In the event of a serious medical emergency and I cannot be contacted, I grant my permission for a physician or hospital staff to perform whatever measures they deem necessary until I can be contacted.

Parents and/or Legal guardian's signature: _____ Date: _____