Sports Medicine Emergency Medical Information

Name:_____ Grade:_____ Age:_____ DOB:_____

Address:_____ Zip:_____

Father/Guardian:_____ Cell#_____ Work#_____

Mother/Guardian:_____ Cell#_____ Work#_____

Athlete Cell#_____ E-mail:_____(optional)

IF PARENTS CAN NOT BE REACHED IN AN EMERGENCY

Name:_____ Cell#_____ Work#_____

Family Physician:_____ Phone#_____

Family Orthopedist:_____ Phone#_____

Preferred Hospital:_____ E.R. Phone#_____

MEDICAL HISTORY

Concussion: Yes/No Date_____ Any diabetic care needed: Yes/No Heart Problem: Yes No Date_____

Diabetic Care _____ Sickle Cell: Yes No Date_____

Medications taken _____ Epi-Pen Needed: Yes/No Date_____

Allergies _____ Contacts/Glasses: Yes/No

Date of last tetanus shot _____
Asthma: Yes/No Will you provide an inhaler: Yes/No
Any other pertinent medical information?

MEDICAL INSURANCE INFORMATION

Company:_____ Policy#_____ Group#_____

Policy Holder:_____ Does plan require referral notice to attend specialist?_____

MEDICAL CONSENT FOR CARE

All athletes, parents, or guardians must assume the risk of injury during athletic events. In the event of such an injury during a practice session, game, or the like: an effort will be made to contact parent/guardian as soon as possible. Permission is granted to the Athletic Trainer/Team Physician/Coach to provide needed emergency care to the athlete prior to his/her arrival at a medical facility. I/we give consent for emergency transport as needed.

Sign one: YES:_____ NO:_____

School Year: 20__ - 20__