



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____