

Emergency Medical Information

Student ID: _____

Sport(s): _____

Class: F So Jr Sr (Circle One)

Athlete's Name: _____ Sex: M / F Birth date: ___/___/___

Address: _____ City _____ Zip _____ Home Phone: _____

Father's Name: _____ Address: _____ E-mail: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Mother's Name: _____ Address: _____ E-mail: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Insurance Co: _____ Hospital Preference: _____

Primary Care Physician: _____ Telephone: _____

Emergency Contact (If parents are unable to be reached): _____

Daytime phone: _____ Evening phone: _____ Relationship to athlete: _____

Address _____

Health History (Please check all that apply and explain in the space provided below)

Medical History:

- Allergies
- Anemia
- Asthma
- Cancer
- Concussions
- Cold / Heat Problems
- Diabetes
- Dizziness with Exercise
- Epilepsy
- Heart conditions
- High Blood Pressure
- Medications
- Respiratory Problems

Do you wear Contacts / Glasses Yes / No

Date of Last Tetnus Shot _____

Explain Medical History: _____

Musculoskeletal History: Indicate Left or Right (if applicable)

- Head / Face
- Neck
- Back
- Shoulder
- Elbow
- Wrist / Hand / Fingers
- Hip
- Knee
- Ankle
- Foot / Toes
- Sprained / Torn Ligaments
- Strained Muscles
- Surgery
- Fractures

Explain Above injuries: _____

I, _____, the parent/guardian of _____ give permission for medical treatment/care of my child, in case of an injury, illness or accident.

Parent signature

Date

Athlete Signature

Date