

**Emergency Medical Information** Student ID: \_\_\_\_\_

Sport(s): \_\_\_\_\_

Athlete's Name: \_\_\_\_\_ Sex: M / F Birth date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

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: \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Chiropractor: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_ Relationship to athlete: \_\_\_\_\_

**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