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 Tetanus 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