

**Emergency Medical Information**

**Sport(s):** \_\_\_\_\_ **Class:** 7 or 8 **School:** \_\_\_\_\_

**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:**

**Musculoskeletal History:** Indicate Left or Right (if applicable)

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

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

Do you wear Contacts / Glasses Yes / No

Date of Last Tetanus Shot \_\_\_\_\_

Explain Above injuries: \_\_\_\_\_

Explain Medical History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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