DIAA School Athlete Medical Card

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: Contact/Personal Information

Name: _____ Sport(s): _____

Age: _____ Grade: _____ Birth Date: _____ Guardian Name: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____ (P) _____

Other authorized person to contact in case of emergency:

Name: _____ Phone(s): _____

Name: _____ Phone(s): _____

Preference of Physician (and permission to contact if needed):

Name: _____ Phone(s): _____

Hospital Preference: _____ Insurance: _____

Policy #: _____ Group: _____ Phone: _____

Section 2: Medical Information

Medical Illnesses: _____

Last Tetanus (mo/yr): _____ Allergies: _____

Medications: _____

(any medications that may be taken during competition require a physician's note)

Previous Head/Neck/Back Injury: _____

Heat Disorder or Sickle Cell Trait: _____

Previous Significant Injuries: _____

Any Other Important Medical Information: _____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of the information as long as the information does not personally identify my child.

➡ Parent/Guardian Signature: X _____ Date: _____

➡ Athlete's Signature: X _____ Date: _____

Section 4: Clearance for Participation

_____ Cleared without restrictions _____ Cleared with the following restrictions: _____

➡ Health Care Provider's Signature: X _____ MD/DO,PA,NP Date: _____

For office use only: This card is valid from **April 1, 2018** through **June 30, 2019.**

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: **St. Andrew's School** ***Name of ATC:*** **Al Wood**