

**MAIDEN HIGH SCHOOL**

**Student Athlete Sports Medicine Form  
Emergency Medical Information & Contact Form  
(Please fill out completely and return to MHS)**

Student-Athlete Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Grade: \_\_\_\_\_ Sport: \_\_\_\_\_  
Name of Coach: \_\_\_\_\_  
Parent or Guardian that Student Resides with: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_

**COMPLETE INFORMATION FOR EACH PARENT/GUARDIAN:**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Address: \_\_\_\_\_  
\_\_\_\_\_  
Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Other Emergency Contact Person: \_\_\_\_\_  
Phone: \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

**INSURANCE INFORMATION:**

Name of Insurance Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Group Number: \_\_\_\_\_

**MEDICAL INFORMATION: (write NONE if not applicable)**

Please list any important medical history/data about this student:  
(EXAMPLE: Previous allergic reactions to insect stings, asthma, medication allergies, sickle cell trait or other special considerations to be made in case of emergency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL AUTHORIZATION FORM:**

I hereby give permission for day-to-day care and emergency treatment of above student-athlete by physicians, school medical staff, coaches, EMTs or hospital emergency room personnel for treatment of any illness or injury resulting from or affecting his/her athletic participation.

Parent/Guardian Signature: \_\_\_\_\_  
Parent/Guardian Printed Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**PLEASE RETURN THIS FORM TO YOUR COACH**

**(Form to be kept in Coach's medical kit and copy given to Athletic Trainer)**