

**CECIL COUNTY PUBLIC SCHOOLS**  
**ATHLETIC EMERGENCY MEDICAL TREATMENT CARD** (Rev. March 2016)

Athlete: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_

**Parent/Guardian Contact Information (If multiple households, please include all information.)**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone(s) Cell/Work/Home: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone(s) Cell/Work/Home: \_\_\_\_\_

**Emergency name and phone if Parent/Guardian cannot be reached:**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone(s) Cell/Work/Home: \_\_\_\_\_

**Insurance/Doctor Information:**

Doctor's Name/ Practice: \_\_\_\_\_

Dentist's Name/ Practice: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

**COMPLETE, SIGN, AND GIVE TO SCHOOL COACH ALONG WITH THE FORM PACKET.**

Allergies (include allergies to bee stings): \_\_\_\_\_

List of current medications: \_\_\_\_\_

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

List significant medical history below. Include specific medical conditions and treatments, surgery, fractures, etc. \_\_\_\_\_

Has student ever experienced a traumatic head injury (a blow to the head)?  Yes  No

If yes, when? Dates (month/year): \_\_\_\_\_

Has student ever received medical attention for a head injury?  Yes  No

If yes, when? Dates (month/year): \_\_\_\_\_

Was student ever diagnosed with a concussion?  Yes  No

If yes, when? please describe the circumstances: \_\_\_\_\_

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

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_