



Athlete Medical Information & Emergency Consent Form

Athlete Information

Full Name: _____ Date of Birth: _____ Age: _____

Grade: _____ Gender: _____

Street Address: _____ City: _____ Zip Code: _____

Mailing Address (if different from street address) _____

Emergency Contact Information

Mother/Guardian Name: _____ Father/Guardian Name: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Alternate Contact Name: _____

Relationship to Athlete: _____

Cell Phone: _____

Medical Insurance & Health Information

Insurance Carrier Name: _____ Policy Number: _____ Last Tetanus Shot: _____

Family Physician Name: _____ Physician Phone Number: _____

Known Allergies: _____

Health Conditions (for emergency physician awareness): _____

Prescription Medications: _____

Parent/Guardian Permission & Consent

I, the undersigned parent/guardian of the above-named athlete, hereby give permission to hospital/emergency staff/athletic trainer & team physician to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child in the event of a medical emergency.

I also grant permission for my child to have injuries & illnesses treated by the athletic trainer & team physician. I also agree that the athletic trainer & team physician can release school health records to individuals deemed necessary by medical personnel for the care and treatment of my child.

I understand that if I choose to have my child treated by another healthcare provider, I am responsible for obtaining a letter or clearance from that provider to give to the athletic trainer. I also understand that all injuries & illnesses must be reported to the athletic trainer.

I acknowledge that the athletic trainer and the team physician have final authority to clear or disqualify my child for athletic activity following any injury or illness.

I give permission for the athletic trainer or team physician to administer any of the following medications not crossed out:

☐ Acetaminophen

☐ Antacid Tablets

☐ Ibuprofen

☐ Benadryl

☐ Throat Lozenges

Parent/Guardian Signature: _____

Date: _____

SECTION 8: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Winter Sport(s): _____ Spring Sport(s): _____

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address _____

Current Home Telephone # () _____ Parent/Guardian Current Cellular Phone # () _____

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name _____ Relationship _____

Parent/Guardian E-mail Address: _____

Address _____ Emergency Contact Telephone # () _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # () _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone # () _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Telephone # () _____

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 9, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

Explain "Yes" answers at the bottom of this form.

Circle questions you don't know the answers to.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? | ☐ | ☐ |

An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below

- | | | |
|--|--------------------------|--------------------------|
| 2. Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? | ☐ | ☐ |
|--|--------------------------|--------------------------|

- | | Yes | No |
|--|--------------------------|--------------------------|
| 3. Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness? | ☐ | ☐ |
| 4. Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain? | ☐ | ☐ |
| 5. Since completion of the CIPPE, are you taking any NEW prescription medicines or pills? | ☐ | ☐ |
| 6. Do you have any concerns that you would like to discuss with a physician? | ☐ | ☐ |

#s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date ____/____/____