PLEASE PRINT CLEARLY AND USE ALL LEGAL NAMES

First Name: _____ Middle Initial: _____ Last Name: _____

Nick Name: _____ Grade: _____ Athlete Home Phone #:_____

Athlete Address: _____ City:_____ ZIP:_____

Athlete E-mail:_____ Birth Date:_____ Sport:_____

Medical History that may be significant to a physician evaluating your child in an emergency situation (Asthma, Diabetes, Genetic Disorders): _____

Is your child on any medication? _____ List: _____

Has your child been prescribed an inhaler? _____ If yes, what type? _____

Please list all allergies (medication/pollen/stings/food): _____

Has your child been prescribed an EpiPen? _____ Type?: _____

Has your child ever sustained a concussion? _____ If yes, how many and when? _____

In case of an emergency please contact in this order:

Name: _____ Relationship to Student: _____

Home: _____ Work: _____ Cell: _____

E-mail:_____

Name: _____ Relationship to Student: _____

Home: _____ Work: _____ Cell: _____

E-mail:_____

Preferred Hospital: _____

Insurance Information

Company: _____ Policy Holder Legal Name: _____

Group Number: _____ Student's Policy/ID number: _____

Effective Date: _____

I, _____, hereby grant permission for my child to be examined and treated by a licensed medical physician, Athletic Trainer, or coach for injuries/illnesses that occur during his/her participation in activities sponsored by Clover Hill High School. I understand that this consent form will only be invoked if school officials are unable to contact a parent/guardian immediately following the discovery of a need for medical attention. I herby certify that the student named above is covered by the medical accident insurance listed above and I accept responsibility for the medical accident insurance of this student.

Parent/Guardian Signature: _____ Date: _____

COACH: Please make a copy and give original to Athletic Trainer