



**PLEASE PRINT CLEARLY AND USE LEGAL NAMES**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade: \_\_\_\_\_ Current Sport: \_\_\_\_\_

Athlete Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Athlete Home Phone #: \_\_\_\_\_ Athlete E-mail: \_\_\_\_\_

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? Yes or No Please list: \_\_\_\_\_

Has your child been prescribed an inhaler? Yes or No If yes, what type? \_\_\_\_\_

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

Has your child been prescribed an EpiPen? Yes or No Type?: \_\_\_\_\_

Has your child ever sustained a concussion? Yes or No  
If yes, how many and when? \_\_\_\_\_

If you have a preference at which hospital your child receives care, please list it here. \_\_\_\_\_  
We will endeavor to use that hospital, but in a life threatening situation, we will use the closest possible.

In case of an emergency, please contact in this order:

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
E-mail: \_\_\_\_\_

Athlete covered by school insurance Date enrolled: \_\_\_\_\_

Athlete covered by the following insurance policy:  
Insurance Company: \_\_\_\_\_ Policy Holder Legal Name: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Student's Policy/ID number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

Athlete is not covered by insurance

I hereby 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: \_\_\_\_\_