

**Athletic Med-Card**

Athlete Name \_\_\_\_\_ School Year 20\_\_ to 20\_\_  
Grade \_\_\_\_\_ Student Cell # \_\_\_\_\_  
Sports participating in \_\_\_\_\_  
Home Address \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Parent/Guardian Phone \_\_\_\_\_  
In an emergency, if we are unable to contact you, do you authorize the school to take your child to the nearest hospital? Yes \_\_\_ No \_\_\_ Hospital Preference in case of emergency \_\_\_\_\_  
Past medical history \_\_\_\_\_  
Medications \_\_\_\_\_  
Allergies \_\_\_\_\_  
Does your child have health insurance? Yes \_\_\_ No \_\_\_ Name on Policy \_\_\_\_\_  
Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
**Administration of OTC (over the counter) Medications:** School personnel (athletic trainer, coaches, etc) may administer the following non-prescription pain relievers:  
Acetaminophen (Tylenol or generic) Yes \_\_\_ No \_\_\_  
Ibuprofen(Advil, Motrin, or generic) Yes \_\_\_ No \_\_\_  
I authorize the certified athletic trainer (ATC), team physician, and/ or coaches to administer care within their scope of practice. Lastly, I will NOT hold the school, its coaches, or school officials/personnel legally responsible for any illness/injury.  
PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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