

Student Athlete Emergency Release and Information Form

To be completed by parent or guardian (please print)

Student's Last Name	First Name	School	Grade
Sport	Male/Female	Student Date of Birth	Age

Check any health problem:

	Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Uses inhaler	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Carries own inhaler	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Carries own epi-pen	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Concussion (head injury)	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Knee injury	<input type="checkbox"/>	<input type="checkbox"/>
Back injury	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder injury	<input type="checkbox"/>	<input type="checkbox"/>	Hip injury	<input type="checkbox"/>	<input type="checkbox"/>
Foot/ankle injury	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Single organ i.e. kidney	<input type="checkbox"/>	<input type="checkbox"/>	Wears dental appliance	<input type="checkbox"/>	<input type="checkbox"/>
Wears glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Explain any checked yes and provide date: _____

Parent/Guardian _____ Relationship _____

Address _____ City, St, Zip _____

Home Tel. No. (_____) Work Tel. No. (_____)

If unable to reach, contact...

(1) Name (Print) _____ Tel. No. _____

(2) Name (Print) _____ Tel. No. _____

Preferred Hospital: _____

Student's M.D. _____ Tel No. _____

Student's Dentist: _____ Tel No. _____

In case of medical emergency, the coach, athletic trainer, or team physician has our consent to apply first aid and secure an ambulance service in case a parent or legal guardian cannot be reached. I also give permission to the physician selected by the school to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as indicated. I will accept responsibility for any expense incurred in handling this emergency care.

I authorize disclosure of health information included on physical forms to trainer/coaches

Signature of parent or legal guardian _____ Date _____

Medical insurance carrier _____