Medical Information Form

Athlete's Name:_____ DOB:_____

Sports:Fall_____Winter_____Spring_____

Address:_____ City:_____ Home Phone:_____

Family Physician:_____ Phone:_____

Emergency Contacts:

1) Parent/Guardian:_____ Phone:_____

2) Other/Relationship:_____ Phone:_____

3) Other/Relationship:_____ Phone:_____

Severe Allergies (medication, food, insect stings, etc) _____

Medical Conditions _____

Current Medications:_____

Recent Surgeries/When: (include wisdom teeth removal):_____

Recent Injuries/When _____

Previous Concussions/When_____

Insurance Information:

Insured Parent:_____

Insurance Company Name:_____

Insurance Policy and Group Number:_____

Parental Consents:

I give my consent for my son/daughter to have impact testing per protocol administered at KASD and to have any injury records or ImPACT test results released to Licensed Athletic Trainer, school nurse, and the treating physician. Information regarding test data may be shared with school personnel for purposes of providing accommodations, if necessary.

Signature:_____**Date:**_____

I give the KASD coach(es) and/or the Certified Athletic Trainer consent to have my son/daughter treated for injury/illness in an emergency situation if I (parent/guardian) am not present.

Signature:_____**Date:**_____

I give consent to my child's health care provider to share any necessary information related to my child's health with the athletic trainer and/or school nurse. I give my consent for the Licensed Athletic Trainer to administer over the counter medications to my child on an as needed basis.

Signature:_____**Date:**_____