INDIANS

Sports Medicine

Taking good care of our athletes!

FORT DEFIANCE HIGH SCHOOL ATHLETICS

Emergency Care & Medical Information

(to be completed by Parents/Guardians of each student athlete each school year)

Please fill out all requested information by printing or typing in blue or black ink.

Athlete's Name: _____ Date of Birth: _____/_____/_____
last, first middle

Mailing Address: _____
street/p.o. box city, state zip

Parent/Guardian's Names: _____
List both Mother's and Father's name

Family physician's Name: _____ Phone #:_____

Dentist's/Orthodontist's Name: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, parents may be contacted at:

Home telephone #: _____

Mother's cellular #: _____ Mother's work #: _____

Father's cellular #: _____ Father's work # _____

Person(s) to call in an emergency if parents cannot be contacted:

Name:	**Phone #:**	**Relationship to student athlete:**
1. _____	_____	_____
2. _____	_____	_____

INSURANCE INFORMATION

NOTE: The ACSB strongly encourages that all children participating in athletics, including athletes, student athletic training assistants, managers and cheerleaders, be protected by personal health insurance or a student accident insurance policy. The VHSL Participation form must be signed by the parent/guardian and submitted to the coach prior to team tryouts. Markel Insurance Company will offer Student Accident Insurance policies for purchase during the school year. More information may be found at: https://markel.sevencorners.com/

Student health or accident insurance information: MUST BE FILLED OUT COMPLETELY

Name of company: _____

Policy Number: _____ Name of policy holder: _____

PERTINENT MEDICAL HISTORY

Please list below any health problems or past pertinent medical history your child has. This is important to know in the case of a serious injury or medical emergency!

_____

_____

Date of last tetanus shot: ***(MM/YYYY)*** _____ ***WE MUST HAVE THIS DATE!***

Please indicate any significant allergies your child has:

Food: _____ Reaction: _____
Insect: _____ Reaction: _____
Medication: _____ Reaction: _____
Other: _____ Reaction: _____

Emergency treatment needed for allergic reactions: _____
_____

Medications taken daily: Provide medication name, dosage, and when taken.

1. _____ Dose: _____ When taken: _____
2. _____ Dose: _____ When taken: _____
3. _____ Dose: _____ When taken: _____
4. _____ Dose: _____ When taken: _____

Please note: If your child requires medications for allergic reactions or other health conditions, (i.e. a bee sting kit, asthma inhaler, etc.) we must have the student's prescribed medication readily available with the coach at ALL athletic practices & events. To protect your son or daughter, please understand that they will NOT be allowed to ATTEND practice/events without the medications on hand.

EMERGENCY AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION:

In the event I cannot be reached in an emergency, I hereby give permission to coaches, athletic training staff, emergency medical staff, and physicians to provide or obtain the treatment deemed necessary for my child.

As a parent or legal guardian of ***(Student Name)*** _____, ***I grant permission for the Certified Athletic Trainer to communicate with other health care providers about the health care of my son/daughter. I also grant permission for the Certified Athletic Trainer to communicate with my son/daughter's coach(es) about medical conditions to relay information such as practice/playing status and treatment & rehabilitation plans.***

Signature of parent/guardian: _____ Date: _____/_____/_____

Print parent name also: _____