



Athletic Training

Authorization for Emergency Medical Treatment

Personal Information

_____			_____		
Last Name	First Name	Middle Name			
_____			_____		
Sport(s)	Class	Age	Date of Birth	Social Security Number	
_____			_____		
Parent/Guardian's Name			Home Address		
_____			_____		
Home Phone Number		Emergency Phone Number	School Phone Number		
_____		_____	_____		

Insurance Information

Health Insurance Agency Name	

Policy Number	

Does your health insurance pre-authorization for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical Information

_____		_____	
Family Physician Name		Family Physician Phone Number	
Check all that apply to your past medical history:			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Wear Contacts
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Serious bone/joint injury	
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hernia/Rupture	<input type="checkbox"/> Wear glasses	
Explain checked boxes below (included list of allergies-bees, medicines, foods):			

List previous surgeries and dates they occurred:			

List ALL medications and nutritional supplements used:			

I, hereby, give my permission for emergency treatment to be provided to me for the medical conditions resulting from my participation in athletics. This treatment will include but not be limited to first-aid, transportation to an emergency facility and other such procedures as the physician and/or athletic training staff deem necessary for the preservation of health.

Athlete's Name (Printed)	Athlete's Signature	Date
**Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date
**Only to be completed if athlete is under 18 years of age		