



## Athletics Medical Information Form

Full Legal Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: (required for treatment at most hospitals) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

List all allergies or medical conditions that would impact treatment: \_\_\_\_\_

Medications taken on a regular basis: \_\_\_\_\_

Name of Parents or Legal Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

List two other emergency contacts:

1. Name and Phone Number: \_\_\_\_\_

2. Name and Phone Number: \_\_\_\_\_

Name of Primary Insurance Policy Owner: \_\_\_\_\_

Insurance Company and Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Secondary Insurance Policy Owner: \_\_\_\_\_

Insurance Company and Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Preferred Hospital or No Preference: \_\_\_\_\_

*I hereby give my permission for authorized personnel of The Habersham School to grant permission for medical treatment for my child, (child's name) \_\_\_\_\_ if I am not readily available, and I authorize the physician and such other health care provider selected by The Habersham School to render such emergency medical treatment as deemed necessary under the circumstances.*

Parent or Legal Guardian Name (printed) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_