

# Fox Creek High School

## Sports Medicine Athletic Information

**THIS FORM IS TO BE COMPLETED AND RETURNED TO THE ATHLETIC TRAINER OR COACHING STAFF.**

***ATHLETE CONTACT INFORMATION:***

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

GRADE \_\_\_\_\_ GENDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ CELL # \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

ZIP CODE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

***GUARDIAN INFORMATION:***

NAME \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_

HOME # \_\_\_\_\_ CELL # \_\_\_\_\_ EMAIL \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_

HOME# \_\_\_\_\_ CELL # \_\_\_\_\_ EMAIL \_\_\_\_\_

***MEDICAL INFORMATION:***

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATION \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ POLICY # \_\_\_\_\_

LIST OF MEDICATIONS ATHLETE CURRENTLY TAKES \_\_\_\_\_

LIST OF ALLERGIES (FOODS, MEDICATIONS, ETC.) \_\_\_\_\_

MEDICAL CONDITIONS: **PLEASE CIRCLE YES OR NO FOR EACH**

ASTHMA- YES/NO                      DIABETES- YES/NO                      HEART MURMUR- YES/NO

CONCUSSION HISTORY- YES/NO    DATE OF LAST CONCUSSION \_\_\_\_\_

SURGERIES \_\_\_\_\_

***MEDICATION PERMISSION: The following medications can be made available for all athletes deemed necessary by the athletic trainer following guidelines and direction of a team physician: COUGH DROPS, ANTIHISTAMINE TABLETS, NON-ASPRIN PAIN RELIEF, ANTI-ACID TABLETS, ANTI-DIARRHEA TABLETS, ANTI-NAUSEA TABLETS, ELECTROLYTE REPLACEMENT TABLETS, ANTI-FUNGAL CREAM, ANTI-BIOTIC OINTMENTS, AND HYDROCORTISONE CREAM.***

\*\*\*\*\* I GIVE MY SON/DAUGHTER PERMISSION TO RECEIVE THESE MEDICATIONS: YES OR NO

I ATTEST THAT THIS INFORMATION ON THIS FORM IS TRUE AND THAT THE COACHES AND ATHLETIC TRAINER MAY USE THIS INFORMATION TO SEEK EMERGENCY CARE OF THE ABOVE NAMED STUDENT ATHLETE. ALL INFORMATION IS GOVERNED UNDER HIPAA AND FERPA VIOLATIONS.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_