

LINDEN ATHLETIC DEPARTMENT EMERGENCY FORM

Name _____ Birthdate _____ M/F

Address _____

Home Phone _____ Graduation Year _____ Insurance Company _____

At least one of the following numbers must be provided:

Contract/Identification # _____ SS# _____

Parent/Guardian's Name _____ Phone _____ Work Cell

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Neighbor, relative or family friend who will care for the athlete if a parent is unavailable:

Name _____ Home Phone _____

Relationship _____ Alternate Phone _____ Work Cell

Primary Physician's Name _____ Phone _____

Allergies _____

Current Medications _____

Special Health Concerns (asthma, diabetes, hypoglycemia, etc). Attach additional sheets as necessary:

High School Sports Involvement (please circle all that apply)

- | | | | | | |
|---------------|------------|------------|-----------------|----------|----------|
| Golf | Basketball | Cheer | Football | Soccer | Softball |
| Cross Country | Wrestling | Volleyball | Track and Field | Baseball | Hockey |
| Gymnastics | Bowling | Ski | Poms | Lacrosse | |

In the event that injury or illness needs immediate medical attention and the designated parties are not available, I understand that appropriate emergency care deemed advisable by school authorities will be sought.

I give permission for the Certified Athletic Trainer (ATC) to examine my athlete and provide treatment as necessary.

There may be instances where the ATC may need to share medical information with in season coaching staff, school administrators, the medical director and student athletic trainers. Information will be shared in accordance with all state and federal guidelines and will only be provided when necessary for proper care/treatment of the athlete or operational purposes. At no time will the ATC share medical information with the media, high school staff not directly involved with the athlete, or other concerned citizens. I understand it is my responsibility to notify the ATC in writing if I do not permit the sharing of medical information.

Furthermore, I give permission for my physician, physical therapist, or other medical professional to release medical information to the certified athletic trainer for purposes of return to play criteria and continued medical care/treatment.

This document is valid for one full calendar year from the date signed.

Signature of parent/legal guardian _____ Date _____

Signature of athlete _____