

SCHOOL YEAR \_\_\_\_\_

**ENHS ATHLETICS MEDICAL INFORMATION**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

HOME PHONE \_\_\_\_\_ (WORK) \_\_\_\_\_ CONTACT NAME \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY

1. \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

2. \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

LIST MAJOR PAST/CURRENT INJURIES/ILLNESSES (Include hospitalizations and dates)

LIST ANY MEDICATIONS YOU TAKE REGULARLY:

LIST ALL ALLERGIES (Foods, medications, insects, etc.):

**MEDICAL TREATMENT CONSENT**

I, the parent/legal guardian of \_\_\_\_\_ give permission to the attending sports medical personnel (i.e. Certified Athletic Trainer, team physician, physical therapist) to provide on-site evaluation and treatment. I authorize the attending O.N.E. sports medicine personnel to discuss the athlete's minimum necessary medical information with appropriate coaching and athletic administrative personnel.

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

HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

ATHLETE'S BIRTH DATE \_\_\_\_\_ HOSPITAL PREFERENCE \_\_\_\_\_

INSURANCE Co. NAME \_\_\_\_\_ ID # \_\_\_\_\_

GROUP # \_\_\_\_\_ BENEFITS PHONE # \_\_\_\_\_

INSURANCE CARRIER NAME \_\_\_\_\_ DOB \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_

What kind of health insurance do you have?

- Private Health Insurance
- Employee sponsored health plan
- Hoosier Healthwise/Medicaid
- None
  
- I do not wish to have my health insurance information released to CANI and do not wish to receive further information regarding the Hoosier Healthwise Program, the state sponsored health insurance plan for children.