SAHS ATHLETICS

Emergency Contact Information

Athlete's Name:_________________________ Birth Date: _________ Gender: __M __F

Grade: _______________ School: _________________________ Sport: ____________________

Address: ____ Home Phone: _____________

Father's Name: ____ Daytime Phone: ___________

Mother's Name: ____ Daytime Phone: ___________

Additional Emergency Contact Person, (In the event neither parent can be reached):

Name: _________________________________ Relation: _____________ Daytime Phone: __________

MEDICAL HISTORY

	Yes	No		Yes	No
Any significant past injuries:			Hospitalizations or surgeries:		
Allergies, Asthma or Wheezing			Seizures		
Contact Lenses or Glasses			Head Injuries or Concussions		
Currently on Medication/Medications			Bone or Joint Injuries		
Chronic Illness			Current on all Vaccinations		
Allergies			Other:		

Comments:

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Medical Authorization: As the parent or legal custodian/guardian of this student athlete, I, __________________________, grant permission for treatment deemed necessary for a condition arising during or affecting participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. Also, permission is granted to release medical information to the school, Athletic Director, Sports Trainer and First Responder.

Parent Signature: ____ Date: _________________