EMERGENCY INFORMATION
ATHLETIC PHYSICAL EXAMINATION

FOR ALL SPORTS
HEALTH EMERGENCY INFORMATION

Student Name ______________________ Class Year ______________ Sex __________

Address ______________ City ______________ State ______________ Zip __________

Home Phone ______________________ Email Address ______________________

List surgeries or hospitalizations (dates):
____

Ever had heart disease, diabetes, bleeding or blood clotting disorders?

What? ____

Ever had a seizure?____________When?________What type?______________________________

Any allergies (hay fever, asthma, hives, medications, insects)? What reactions?

____

Date of last physical? ______________________

Date of last tetanus:___________________________

Do you wear contacts?_________________________

Are you taking any medication?__________What?________________When?________________

Other Health History:

____

Mother/Guardian ______________________________ Work Phone ______________

Father/Guardian ______________________________ Work Phone ______________

IF PARENTS / GUARDIAN CANNOT BE REACHED CONTACT"

Local Physician:____PH#__________________
Recommended Hospital:____
Insurance Co.____PH#__________________

In case of an accident or serious medical problem, I request the school to contact me (the above named parent/guardian). If the school is unable to contact me, I hereby authorize the school to contact the above named alternate person. If it is impossible to contact any so authorized person, the school may make whatever transportation and medical arrangements seem necessary.

SIGNATURE (PARENT/GUARDIAN)______________________________________DATE_________________