Colonial Heights High School Athletic Training Department

PLEASE FILL OUT ENTIRELY, AS THIS FORM IS USED FOR MEDICAL CORRESPONDENCE

First Name: ____________________ Middle Initial: _____ Last Name: ____________________

Preferred Name: ____________________ DOB: ____/____/____ Grade: ______ Gender: ___________

Athlete Cell Phone #: ____________________ Athlete E-mail: ______________________________

Athlete Address: ____________________________________ City: _________________ Zip: __________

Current Sport: _______________________

Please list medical history that may be significant to a physician evaluating your child in an emergency situation:

(ie. Asthma, Diabetes, Genetic Disorders): ____

Please list all allergies (medication/seasonal/stings/food): ____________________________________

Is your child on any medication? (Yes) or (No) Please list: ______________________________

Has your child been prescribed an inhaler? (Yes) or (No) If yes, what type? ___________________

Has your child been prescribed an EpiPen? (Yes) or (No) If yes, what type? ___________________

Has your child ever sustained a concussion? (Yes) or (No)

If yes, how many and when? ____

In case of an emergency, please contact in this order:

Name: __________________________ Relationship to Student: _______________________

Home: ___________________ Cell: ___________________ Work: ___________________

E-mail: ____

Name: __________________________ Relationship to Student: _______________________

Home: ___________________ Cell: ___________________ Work: ___________________

E-mail: ____

*If you have a preference at which hospital your child receives care, please list it here: ____________________

We will endeavor to use that hospital, but in a life threatening situation, we will use the closest possible.

[ ] Athlete covered by school insurance Date enrolled: _______________________

[ ] Athlete covered by the following insurance policy:

Insurance Company: ________________________________

Policy Holder Legal Name: _____________________ Effective Date: ____________________

Policy/ID number: ________________________ Group Number: ____________________

[ ] Athlete is not covered by insurance

I herby certify that the student named above is NOT covered by medical accident insurance and I fully accept responsibility for all medical related costs associated with sport participation of this student.

Parent/Guardian Signature: __________________________________ **Date:** _______________

Please contact Colonial Heights athletic trainer Amber Cook: 804-694-7761 or Amber.Cook3@HCAHealthcare.com with any medical related questions or concerns pertaining to this document