

# EMERGENCY TREATMENT INFORMATION

## Central Maryland Attitude Girls Basketball

### PERSONAL INFORMATION (please print clearly)

Name: \_\_\_\_\_ Gender: Male/Female Date of Birth: \_\_\_/\_\_\_/\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Mother: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Father: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Are you covered by accident/medical insurance? Yes / No

If yes, please complete the following.

Insurance Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

### MEDICAL HISTORY

Medical Illness: Do you have any of the following conditions? (Please circle ALL that apply)

*\*If asthma is circled, the athlete must have his/her inhaler while participating in ANY athletic activity.*

Anemia      Asthma      Diabetes      High Blood Pressure      Epilepsy

Other: \_\_\_\_\_

Do you take any medications on a regular basis? Yes / No If Yes (list all) \_\_\_\_\_

Do you have allergies? Yes / No If Yes (list all) \_\_\_\_\_

Do you have any previous or existing injuries? Yes / No If Yes (list all) \_\_\_\_\_

Do you wear glasses? Yes / No      Contacts? Yes / No

When was your last tetanus booster shot? \_\_\_/\_\_\_/\_\_\_ (month/year)

Should it become necessary for this athlete to require medical treatment while participating in an athletic event/trip or practice session, I hereby authorize the health care providers (athletic trainers, physicians, and emergency medical technicians – EMT's) to provide medical care to my child and/or obtain appropriate medical services. Furthermore, if the health care personnel or coach are unable to reach those designated above I give permission to the health care personnel or coach to take my child to a hospital, emergency care center, or available physician and obtain treatment by the hospital, emergency care center, or available physician.

Signature: \_\_\_\_\_

(Parent/Guardian)

Date: \_\_\_/\_\_\_/\_\_\_