SPORTS HEALTH INFORMATION FORM

EMERGENCY CONTACT INFORMATION

[Please do not leave any blanks unfilled]

Athlete's Name _____ Email_____

Sex _____ Age _____ Date of Birth _____Grade _____ Student Cell #_____

Allergies/ Medication Allergies_____ Current Medications: _____

Significant Medical History/Existing Conditions _____

Sickle Cell Trait/Anemia: Yes / No

Mailing Address _____ City _____ Zip _____

Home Phone: _____ Student's Cell Phone: _____

Mother's Name _____ Phone _____ Cell/Other _____ Email _____

Father's Name _____ Phone _____ Cell/Other _____ Email _____

In an EMERGENCY, if the Parents cannot be reached, please notify:

Name _____ Relation _____ Cell _____ Other # _____

Preferred Hospital _____

Family Doctor _____ Phone _____ Family Dentist _____ Phone _____

HEALTH INSURANCE INFORMATION

Do you have health insurance? **Y / N** Do you have Medicaid? **Y / N** Medicaid Number_____

Name of Company _____Mailing Address _____

Insured's Name _____ Policy # _____

Does your insurance plan require you to be seen by your primary care physician before being seen by a specialist? **Y / N**

Does your insurance require a second opinion before surgery? **Y / N**

*****Lexington School District 1 carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to help pay secondarily to the athlete's primary health insurance. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing a Lexington Co. District One School, the athlete should seek the attention of the sports medicine staff as soon as possible. A staff athletic trainer will fill out the top portion of the insurance claim form (AKA Notification of Injury Form). If the injury is a non-emergency, the form should be filled out prior to a physician visit. The parent/ guardian should complete the claim form, follow the attached directions, and mail the completed form to the insurance company.**

**** Sports Medicine staff should be notified of injury immediately or claim may be invalid. Please note the claim must be filed within 90 days of injury.*

CONSENT TO PARTICIPATE IN ATHLETICS AND RISK WAIVER

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that the pre-participation physical examination is simply a screening evaluation and not a substitute for regular healthcare. I grant permission to nurses, certified athletic trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means.

CONSENT FOR MEDICAL TREATMENT/RELEASE OF INFORMATION/ DUTY TO REPORT INJURIES

I/We give consent for certified athletic trainers, coaches, and physicians to use their own judgment in securing medical aid and ambulance service in the case the parents/guardians cannot be reached. In the event of an accident requiring immediate medical attention, I herby grant permission to physicians, certified athletic trainers, and/or appropriate healthcare professionals to attend to my son/daughter. It is understood that the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I/We give permission for our son/ daughter to be evaluated and treated by the on-site home or away certified athletic training staff and/or team physicians if he/she becomes injured while participating as an athlete of a Lexington Co. District One School. I/We also authorize the school's sports medicine staff to be given medical information concerning my son/daughter by a physician or their staff. Likewise, the school's sports medicine staff may release medical information to physician's offices, coaching staff, nurses, administrators and faculty at the school as they see appropriate. I also commit to reporting **ALL** injuries to the Sports Medicine Staff, including but not limited to any symptoms related to a concussion. I also understand that the sports medicine staff will follow return to play protocols for all injuries**.**

Student's Signature _____ *Date* _____

Parent's Signature _____ *Date* _____