NORTHWESTERN LEHIGH BAND EMERGENCY CONTACT & MEDICAL HISTORY FORM

Student's Name

Date of Birth

Grade

Student's Gender

Student Email

Parent's/Guardian's Name

( )

Cell Phone

( )

Home Phone

Parent's/Guardian's Name

( )

Cell Phone

( )

Home Phone

Address

City, State ZIP Code

E-Mail

Address

City, State ZIP Code

E-Mail

Alternate Emergency Contacts

Primary Emergency Contact

( )

Telephone

Address

City, ST ZIP Code

Secondary Emergency Contact (Optional)

( )

Telephone

Address

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

Date of Last Tetanus Shot _____

Any Medical Conditions _____
_____

Allergies (List All) _____
_____

Any other info that we may need to know _____
_____

Are we allowed to give your child an over the counter pain medication if needed (ex. Tylenol, Motrin, Advil, etc.)? **YES NO** Dosage _____ Preferred Medication? _____
If **YES**, please provide medication in the original container marked with the child's name on it.

MEDICAL HISTORY (Please provide dates)

1. Previous injuries:
   a. Head/Neck _____
   b. Upper Extremity _____
   c. Lower Extremity _____
   d. Trunk _____

   Explain Checked Items: _____
   _____
   _____

2. Previous bone or joint problems not stated above:
   _____
   _____
   _____

3. Previous surgery: (List All)
   _____
   _____
   _____

4. Is your child presently under a doctor's care? YES OR NO
   a. If yes, explain: _____
   _____

5. Does your child wear:
   Glasses YES OR NO Contacts YES OR NO
   Braces YES OR NO False Teeth YES OR NO

6. List all prescribed medications which your child is presently taking:
   _____
   _____
   _____

7. Does your child have a loss or impaired function of any organ?
   YES OR NO
   If yes, explain: _____
   _____
   _____

8. Place a check if your child has / had:
   Allergies _____ Concussion _____
   Asthma _____ Diabetes _____
   Epilepsy _____ Convulsions _____
   Frequent Headaches/Migraines _____
   Heart Trouble _____ Heat Illness _____
   High Blood Pressure _____
   Mononucleosis _____
   Explain any yes responses: _____
   _____
   _____

If your child should suffer an injury requiring emergency hospital treatment and in the event you cannot be contacted, **DO YOU AUTHORIZE HOSPITAL PERSONNEL TO ADMINISTER WHATEVER TREATMENT MAY BE DEEMED NECESSARY?**

YES OR NO Parental Signature: _____ Date: _____

I hereby give permission for emergency treatment by the team physician and/or athletic trainer. This will include, but not limited to, diagnostic x-rays and other procedures the physician and/or athletic trainer feels necessary for preservation of health. I also grant permission to the school district's contracted healthcare providers to disclose information to the coach, A.D., Principal, or benefits specialist only, regarding my child's injuries and general fitness as deemed appropriate and within the guidelines set forth by HIPAA/ FERPA

Parental Signature: _____ Date: _____