CECIL COUNTY PUBLIC SCHOOLS
ATHLETIC EMERGENCY MEDICAL TREATMENT CARD (Rev. March 2016)

Athlete: ______________________________ **DOB:** ______________

Home Address: ____

____

Parent/Guardian Contact Information (If multiple households, please include all information.)

Name: ______________________ **Relationship to student:** ______________

Phone(s) Cell/Work/Home: ______________________________________

Name: ______________________ **Relationship to student:** ______________

Phone(s) Cell/Work/Home: ______________________________________

Emergency name and phone if Parent/Guardian cannot be reached:

Name: ______________________ **Relationship to student:** ______________

Phone(s) Cell/Work/Home: ______________________________________

Insurance/Doctor Information:

Doctor's Name/ Practice: ______________________________________

Dentist's Name/ Practice: ______________________________________

Health Insurance Company: ________________ **Group/Policy #:** ______________

COMPLETE REVERSE SIDE AND SIGN

CECIL COUNTY PUBLIC SCHOOLS
ATHLETIC EMERGENCY MEDICAL TREATMENT CARD (Rev. March 2016)

Athlete: ______________________________ **DOB:** ______________

Home Address: ____

____

Parent/Guardian Contact Information (If multiple households, please include all information.)

Name: ______________________ **Relationship to student:** ______________

Phone(s) Cell/Work/Home: ______________________________________

Name: ______________________ **Relationship to student:** ______________

Phone(s) Cell/Work/Home: ______________________________________

Emergency name and phone if Parent/Guardian cannot be reached:

Name: ______________________ **Relationship to student:** ______________

Phone(s) Cell/Work/Home: ______________________________________

Insurance/Doctor Information:

Doctor's Name/ Practice: ______________________________________

Dentist's Name/ Practice: ______________________________________

Health Insurance Company: ________________ **Group/Policy #:** ______________

COMPLETE REVERSE SIDE AND SIGN

Allergies (include allergies to bee stings): ____

____

List of current medications: ____

____

Date of Last Tetanus Shot: ____

List significant medical history below. Include specific medical conditions and treatments, surgery, fractures, etc. __________

____

____

Has student ever experienced a traumatic head injury (a blow to the head)? ☐ **Yes** ☐ **No**

If yes, when? Dates (month/year): ____

Has student ever received medical attention for a head injury? ☐ **Yes** ☐ **No**

If yes, when? Dates (month/year): ____

Was student ever diagnosed with a concussion? ☐ **Yes** ☐ **No**

If yes, when? please describe the circumstances: ____

____

____

Parent/Guardian Signature: ______________________________ **Date:** ______________

Student-Athlete Signature: ______________________________ **Date:** ______________

Allergies (include allergies to bee stings): ____

____

List of current medications: ____

____

Date of Last Tetanus Shot: ____

List significant medical history below. Include specific medical conditions and treatments, surgery, fractures, etc. __________

____

____

Has student ever experienced a traumatic head injury (a blow to the head)? ☐ **Yes** ☐ **No**

If yes, when? Dates (month/year): ____

Has student ever received medical attention for a head injury? ☐ **Yes** ☐ **No**

If yes, when? Dates (month/year): ____

Was student ever diagnosed with a concussion? ☐ **Yes** ☐ **No**

If yes, when? please describe the circumstances: ____

____

____

Parent/Guardian Signature: ______________________________ **Date:** ______________

Student-Athlete Signature: ______________________________ **Date:** ______________