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: _____

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:** _____