

GENERAL INFORMATION

Students Legal Name

Birthday

Grade

Sex

Present Address

City

Zip

Students E- Mail Address

Parents E-Mail Address

Students Cell

(#1) Emergency Contact & Phone Number

(#2) Emergency Contact & Phone #

Father Name & Phone #

Mother's Name & Phone #

Cell #

Work #

Cell #

Work #

Medical/ Insurance Information

Insurance Provider & Policy #

Insured employer

Family Physician & Phone #

Existing medical conditions (medications allergies- bee stings)

MEDICAL HISTORY

YES	NO	DON'T KNOW	QUESTIONS
			1. Are you aware of any health problems?
			2. Does the athlete take any medic
			3. Is the athlete currently under medical care?
			4. Does the athlete have any problems with vision (ey
			5. Has the athlete ever suffered a heart related illness (heart Stroke?
			6. Does the athlete have history of a concussion (getting knocked out)?
			7. Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise?
			8. Has the athlete ever broken a bone, has to wear a cast or had an injury to any joints?
			9. Has it ever been necessary to restrict athlete's activities for medical reason?
			10. Does athlete require special care for any reason
			11. Has the athlete ever had any surgeries?
			12. Is the athlete diabetic?

- Explain any YES answers (Attach additional page if necessary)

PARENT'S STATEMENT I hereby give my consent for the above named student to compete in sports, including regularly scheduled trips to other schools on supervised school transportation and I certify that the insurance information provided is accurate. **Risk Warning:** I realize that participating in competitive athletics may result in severe injury, including paralysis or death. It is understood Break The Hudl and or any Break The Hudl employee shares NO responsibility in the payment of medical fees incurred by injuries to participants in its athletic programs. **Trainer Consent:** I give my permission to the athletic trainer or other district personnel to administer first aid, follow-up treatment and rehabilitation when appropriate in his or her professional judgment as approved by the consulting physician. **Emergency Treatment:** In the event of an accident or emergency, I give my permission for the school authorities to transport my child to any available doctor or hospital or request their services.

DATE: _____

Parent/Guardian Signature: _____