

AT – 14

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| Athlete Data and Emergency Treatment Information |

Name (Last, First, MI) DCPS Student ID#

Street City State Zip

Gender [ ]  Male [ ]  Female Date of Birth Grade

School School Year

**Emergency Contact-Please provide at least 2 Contacts (\*Parent/Guardian should be listed first as Primary Contact)**

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| --- | --- | --- | --- | --- |
| **Name** | **Relationship** | **Home** | **Work** | **Mobile** |
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**Insurance & Billing**

Insurance Co. Policy # Insurance Co. Phone

Policy Holder’s Name Effective Date

**Do you have any of the following conditions** (check all that apply)?

[ ]  Anemia [ ]  Asthma (Inhaler Type) [ ]  Sickle Cell / Sickle Cell Trait [ ]  Diabetes

[ ]  Epilepsy [ ]  High Blood Pressure [ ]  Previous Concussion/Head Injury; if yes, date?

[ ]  Allergies Other

Do you wear contacts or glasses? [ ]  Contacts [ ]  Glasses

When was your last tetanus booster? Month/Year

List all medications currently used including prescribed, over the counter and rescue inhalers

**Should it become necessary for this student to require medical treatment while participating in an interscholastic athletic event, trip, or practice session, I hereby authorize the District of Columbia Public School’s health care providers (athletic trainers, team/game physicians and emergency medical technicians (EMT’s)) to provide athletic medical care to my child and/or obtain appropriate medical services. Furthermore, if DCPS personnel are unable to reach those designated above, I give my consent to the DCPS athletic health care providers to take my child to a hospital, emergency care center or available physician.**

**Signature Date**

 **(Parent, Guardian or Student 18yrs+)**

 **For Office Use Only:**

 Date of DC Universal Health Certificate (Physical) AT/SC Initials:

District of Columbia Public Schools Department of Athletics Athletic Health Care Services Revised 5/2013