



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

Name	Relationship	Home	Work	Mobile

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 _____
(Parent, Guardian or Student 18 yrs+)

Date _____

For Office Use Only:

Date of DC Universal Health Certificate (Physical) _____

AT/SC Initials: _____