



# CLINTON ATHLETICS

## EMERGENCY MEDICAL HEALTH INFORMATION

STUDENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(LAST) (FIRST)

SCHOOL: \_\_\_\_\_ HOMEROOM: \_\_\_\_\_

PARENT/GUARDIAN - NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE : (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

ALTERNATE EMERGENCY CONTACT - NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS?

1. DIABETES YES OR NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

2. ASTHMA YES OR NO

IF YES, DO YOU USE AN INHALER? \_\_\_\_\_

3. ALLERGIES YES OR NO

IF YES, DO YOU USE AN EPI-PEN? \_\_\_\_\_

IF YES, DO YOU TAKE ANY SPECIAL MEDICATIONS? \_\_\_\_\_

4. SEIZURES YES OR NO

IF YES, DO YOU TAKE ANY MEDICATION? \_\_\_\_\_

5. HEART CONDITIONS YES OR NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

6. MEDICATIONS – PLEASE LIST ANY MEDICATIONS THAT YOUR CHILD IS CURRENTLY TAKING: \_\_\_\_\_

IN THE EVENT OF INJURY OR ILLNESS TO MY CHILD, I GRANT PERMISSION FOR SCHOOL PERSONNEL TO CONTACT MEDICAL PERSONNEL WITHOUT MY KNOWLEDGE FOR MY CHILD'S TREATMENT.

\_\_\_\_\_  
(PARENT'S SIGNATURE)

\_\_\_\_\_  
(DATE)