

Irvington Community School • Athletic Department

Emergency Contact Form

Name _____	Sport(s) _____
Address _____	Sex _____
_____	Grade _____ DOB ____/____/____

MEDICAL HISTORY

Please answer the following questions and provide a brief explanation of all YES answers as well as dates where needed. This information will allow the Athletic Department to make educated decisions regarding the student-athlete's health.

In the past year, have you had, or do you now have:	NO	YES	Explain any "YES" answers and GIVE DATES:
Any injuries requiring medical attention?			
Any surgical operations or hospitalizations?			
A concussion? How many? WHEN?			
Convulsions or seizures (fits) for which you are now being treated			
Recurrent headaches?			
Asthma/ breathing difficulty/ cough with exercise? Inhaler?			
The use of only one eye or a history of any injury to the eye?			
Heart murmur, heart problems, history of rheumatic fever?			
Has any member of your family died suddenly of a heart related issue?			
High blood pressure?			
Only one kidney or (boys) one or both testicles not descended?			
Any problems with neck, back, shoulder, hips, or knees?			
Diabetes (sugar)?			
Hemophilia (Are you a bleeder?)			
Anorexia/ bulimia/ eating disorder?			
Mononucleosis?			
Chest pain with exercise?			
Do you tire quickly?			
Had any allergic reactions to food, medications or insects?			
Wear glasses, contacts, or medical braces during sports activity?			
Is any doctor currently treating you for any disorder?			
Are you currently taking any medication(s)?			
Any problems with your health that might affect your ability to participate in athletic activities?			
Do you know of any reason why you should not participate in any specific athletic activity?			
Do you have health and accident insurance?			

**Please fill out the following information completely, accurately and neatly –
This information is important to ensure the welfare of your student-athlete!**

Primary Contact/Relationship _____	Home Ph# _____
	Work Ph# _____
Secondary Contact/Relationship _____	Home Ph# _____
	Work Ph# _____
Alternate Contact/Relationship _____	Home Ph# _____
	Work Ph# _____

In the event of serious or potentially serious medical emergency, I grant permission for medically trained school staff to perform supportive measures until I can be contacted, professional medical personnel can attend, or transportation to a medical facility can be arranged. I, the undersigned, certify that the answers to the above questions are correct and true.

Student's Signature _____ Date _____

Parent's Signature _____ Date _____