

Athlete Data and Emergency Treatment Information

Name *(Last, First MI)* _____ Athlete ID # *(Enter DCPS Student # or last 4 digits of SS#)* _____
 Street _____ City _____ Zip _____
 Gender Male Female Date of Birth _____ Grade _____
 School _____ SY _____

Sports

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Baseball – JV | <input type="checkbox"/> Crew | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Soccer – Varsity |
| <input type="checkbox"/> Baseball – Varsity | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Indoor Track | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Basketball – JV | <input type="checkbox"/> Football – JV | <input type="checkbox"/> Outdoor Track | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Basketball – Varsity | <input type="checkbox"/> Football – Varsity | <input type="checkbox"/> Softball | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Golf | <input type="checkbox"/> Soccer – JV | <input type="checkbox"/> Wrestling |

Emergency Contact

Contact	Primary Relationship	Phone 1	Type	Phone 2	Type

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 Allergies Diabetes
 Epilepsy High Blood Pressure Other _____

Do you wear contacts or glasses? Contacts Glasses

When was your last tetanus booster? Month/Year _____

List all other conditions and all medications currently taken _____

Should it become necessary for this student to require medical treatment while participating in an interscholastic athletic event/trip of 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 _____