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

☐ Baseball – JV	☐ Crew	☐ Lacrosse	☐ Soccer – Varsity
☐ Baseball – Varsity	☐ Cross Country	☐ Indoor Track	☐ Swimming
☐ Basketball – JV	☐ Football – JV	☐ Outdoor Track	☐ Tennis
☐ Basketball – Varsity	☐ Football – Varsity	☐ Softball	☐ Volleyball
☐ Cheerleading	☐ Golf	☐ Soccer – JV	☐ 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 _____