

Madison East Sports Medicine
Medical Information

Student Name _____ Date of birth _____ Grade _____

Parent/Guardian Name _____

Street Address/City/State/Zip _____

Phone _____ Phone 2: _____

List two people as emergency contacts (other than above):

Name: _____ Relation: _____

Phone: _____ Phone 2: _____

Name: _____ Relation: _____

Phone: _____ Phone 2: _____

Physician: _____ Clinic/Hospital: _____

Primary Insurance Company: _____ Group Number: _____

Madison East Sports Medicine
Medical Information

List all allergies (food, bee stings, medications/drugs): _____

List all current medications/drugs: _____

List all prior sports injuries: _____

List other significant illness/injury: _____

Permission for emergency treatment: _____ Signature: _____

Name: _____ Date: _____