ATHLETIC MEDICAL CARD

Name_____Age_____
Address_____Home Phone_____
Father's Name_____Cell Phone_____
Employment_____Work Phone_____
Mother's Name_____Cell Phone_____
Employment_____Work Phone_____
Drug Allergies_____
Current Medications_____
Special Health Problems_____
Doctor's Name_____Hospital Preference_____
Medical Insurance Carrier_____Policy #(s)_____
Alternative Person to Contact_____Phone_____Cell_____

(Circle One)
Yes No 1. Has had injuries requiring medical attention.
Yes. No 2. Has had illness lasting more than a week.
Yes No 3. Is under physician's care now.
Yes No 4. Takes medication now.
Yes No 5. Wears glasses (Contact lenses Yes No)
Yes No 6. Has had a surgical operation.
Yes No 7. Has been in hospital (except for tonsillectomy)
Yes No 8. Do you know of any reason why the individual should not participate in sports?
Yes No 9. Any know allergies.
Please explain any "yes" answers to above questions.

SUMMIT