

Gilbert High School Sports Medicine Form

(Please Print)

Emergency Information

Athlete's Name _____ SS# _____
Sex _____ Age _____ Date of Birth _____ Grade _____ School Year _____
Mailing Address _____ City _____ Zip _____
Home Phone # _____
Mother's Name _____ Phone # _____ Business # _____
Father's Name _____ Phone # _____ Business # _____

In an EMERGENCY, if parents cannot be contacted notify:

Name _____ Phone # _____
Family Doctor _____ Phone # _____
Family Dentist _____ Phone # _____
Preferred Hospital _____
Allergies _____ Glasses/Contacts _____
Significant Medical History/Existing Condition: _____

Insurance Information

Do you have health insurance _____
Name of Company _____ Mailing Address _____
Insured's Name _____ SS # _____ Policy # _____
Are you a member of an HMO, or other managed healthcare plan? _____
Does your insurance require a second opinion before surgery? _____

*** Lexington School District One carries secondary health insurance on all its athletes. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing Gilbert High School, the athlete should seek the attention of the certified athletic trainer as soon as possible so that a claim may be filed promptly. The certified athletic trainer will fill out a portion of the claim form and mail the form to the parent/guardian of the injured athlete. The parent/guardian should complete and mail the claim form to the insurance company. ****

Consent For Medical Treatment/ Release of Information

I/We give consent for the certified athletic trainers, coaches, and team physicians to use their own judgment in securing medical aid and ambulance service in the case the parents/guardians cannot be reached. In the event of an accident requiring immediate medical attention, I hereby grant permission to a physician, certified athletic trainer, and/or appropriate healthcare professional to attend to my son/daughter/ward. It is understood that the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I/We give permission for my/our son/daughter/ward _____ to be evaluated and treated by the certified athletic trainers, Byron C. Millwood or any member of the sports medicine department of Gilbert High School, if he/she becomes injured while participating as an athlete at Gilbert High School during the _____ school year. I/We also authorize Byron C. Millwood or the sports medicine department of Gilbert High School, to be given medical information concerning my son/daughter/ward by any physician. Likewise, Byron C. Millwood or the sports medicine department of Gilbert High School, may release this information to the coaching staff at Gilbert High School as they sees appropriate.

Parent's Signature _____ Date _____
