HCA Va Sports Medicine
An HCA affiliate

PLEASE PRINT CLEARLY AND USE ALL LEGAL NAMES

First Name: _____ Middle Initial: _____ Last Name: _____
Nick Name: _____ Grade: _____ DOB: _____ Athlete Home Phone #:_____
Athlete Cell Phone: #:_____ Athlete E-mail:_____
Athlete Address: _____ City: _____ State: VA Zip Code: _____
Current Level: JV or Varsity Current Sport: _____

Medical History that may be significant to a physician evaluating your child in an emergency situation (Asthma, Diabetes, Genetic Disorders): _____

Is your child on any medication? Yes or No If yes, what type? _____

Has your child been prescribed an inhaler? Yes or No If yes, what type? _____

Please list all allergies (medication/pollen/stings/food): _____
Has your child been prescribed an EpiPen? Yes or No

Has your child ever sustained a concussion? Yes or No If yes, how many and when? _____

In case of an emergency please contact in this order:
Name: _____ Relationship to Athlete: _____
Home: _____ Cell: _____ Work: _____
E-mail:_____

Name: _____ Relationship to Athlete: _____
Home: _____ Cell: _____ Work: _____
E-mail:_____

In case of an emergency, do you have a hospital preference for your child to receive care? Yes or No

If yes, which hospital? _____. We will endeavor to use your preference, however in a life threatening situation, the closest hospital will be used.

[ ] Athlete covered by school insurance Date enrolled: _____

[ ] Athlete covered by the following insurance policy:
Insurance Company: _____ Policy Holder Legal Name: _____
Group Number: _____ Student's Policy/ID number: _____
Effective Date: _____

[ ] Athlete is not covered by insurance

I herby certify that the student named above is covered by the medical accident insurance listed above and I accept responsibility for the medical accident insurance of this student.

Parent/Guardian Signature: _____ Date: _____

Signature of Athlete: _____ Date: _____

Please sign and return to your COACH or the ATHLETIC TRAINER prior to the beginning of the athletic season