VCU Health

SPORTS MEDICINE

ATHLETE INFORMATION

Athlete's Full Legal Name: _____ Male Female DOB: _____
Nickname: _____ Grade: _____ Sport: _____ JV or Varsity
Home Address: _____
City: _____ State: _____ Zip: _____
Phone number: _____ Email Address: _____

EMERGENCY MEDICAL INFORMATION

Please list all medical history that may be pertinent for a medical professional to know in the event of an emergency (asthma, diabetes, sickle cell trait, other genetic disorders): _____
_____
_____

Is your child on any medication? **Yes or No** If so, please specify: _____
Please list all allergies: _____
Has your child been prescribed an EpiPen? **Yes or No** Has your child been prescribed an inhaler? **Yes or No**

	Emergency Contact	**Secondary Emergency Contact Person(s)**
Name(s)		
E-mail(s)		
Work/Cell #s		
Relationship to Athlete		

INSURANCE INFORMATION

Does your insurance require a referral from your PCP (primary care physician) to see another Dr. or Specialist?
YES NO
If yes list: Primary Care Physician: _____ Phone Number: _____

[ ] Athlete is covered by *school* insurance Date enrolled: _____
[ ] Athlete has *primary* insurance coverage Insurance Company _____
Policy Holder Legal Name _____ Insurance ID # _____
Policy Group # _____ Policy Holder's Relationship to athlete _____
Policy Holder's DOB _____Contact Phone Number _____
Type of Insurance: **Traditional HMO PPO POS Other** _____

[ ] Athlete has *secondary* insurance coverage Insurance Company _____
Policy Holder Legal Name _____ Insurance ID # _____
Policy Group # _____ Policy Holder's Relationship to athlete _____
Policy Holder's DOB _____Policy Holder's Phone Number _____
Type of Insurance: **Traditional HMO PPO POS Other** _____

[ ] Athlete is *NOT* covered by insurance

Please sign and return to your athlete's coach or the athletic trainer at your high school.