

**Northampton High School**  
**DEPARTMENT OF ATHLETICS**  
**MEDICAL EMERGENCY FORM**

**IT IS IMPERATIVE THAT ALL ITEMS BE COMPLETED AND LEGIBLE.  
PRINT ALL INFORMATION**

Date: \_\_\_\_\_

\_\_\_\_\_  
(Student's Last Name) (First Name) (Middle Initial)

Grade \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residential Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Mailing Address \_\_\_\_\_  
(if different)

\_\_\_\_\_  
(City) (State) (Zip)

**Parent/Guardian Information**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Workplace: \_\_\_\_\_ Workplace: \_\_\_\_\_

Phone:( ) \_\_\_\_\_ ( ) \_\_\_\_\_ Phone:( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Work Home Work

Cell Phone:( ) \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_

Other adults who will assume responsibility or provide transportation if parent cannot be reached in an emergency. Please remember that practices, games, and meets are after the regular school day:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Dentist and/ or Orthodontist: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

Name of company or Health plan: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy # (**MUST BE LISTED**): \_\_\_\_\_

**-Additional Information Needed on Other Side-**

**Athlete's Name:** \_\_\_\_\_

**MEDICAL HISTORY AND CURRENT INFORMATION**

**Life threatening allergies:**

Bee Sting: Yes No (Circle one)      Latex: Yes No (Circle one)      Other \_\_\_\_\_

Food: Yes No (Circle one) Please name food(s) if yes \_\_\_\_\_

• If yes to any of the life-threatening allergies, does student have an Epi-pen? Yes No (Circle one)

Does student know how to use the Epi-pen? Yes No (Circle one)

Does student carry any other allergy medications? Yes No (Circle one)

If yes please name medications: \_\_\_\_\_

**History of concussion/head injury:** Yes No (Circle one)

If yes, how many? \_\_\_\_\_ Date of most recent \_\_\_\_\_

**Diabetes:** Yes No (Circle one) If yes, how is diabetes controlled? \_\_\_\_\_

**Asthma:** Yes No (Circle one) If yes, what inhaler(s) or other medication are used? \_\_\_\_\_

**Seizures:** Yes No (Circle one) If yes, what medications are used? \_\_\_\_\_

**Any other current medications:** \_\_\_\_\_

(Please remember that a Health Care Provider's order and a parent consent form must be on file in the school health office for any medication needed during school)

**Other serious illnesses:** (with dates, please)

**Other chronic health problems:** (please include time frame)

**Operations:** (with dates, please)

**Fractures or other injuries:** (with dates, please)

**Date of last tetanus booster:** \_\_\_\_\_

**I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.**

***MEDICAL EMERGENCY AUTHORIZATION: I GIVE PERMISSION FOR THE STAFF AND COACHES OF THE NORTHAMPTON HIGH SCHOOL DEPARTMENT OF ATHLETICS, HOSPITAL, PHYSICIAN, OR OTHER EMERGENCY MEDICAL STAFF TO DETERMINE IF EMERGENCY CARE IS NEEDED, AND TO PROVIDE SAID CARE, FOR MY CHILD.***

\_\_\_\_\_  
(Signature of Parent or Guardian)      Date \_\_\_\_\_