Student Information:

Last Name _____ First Name _____Middle Initial_____

Sport/(s) _____ Grade _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone: _____ Student Cell Phone: _____

Parents Information:

Mothers Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Fathers Name: _____

Address: _____

_____

Home Phone _____

Work Phone: _____

Cell Phone: _____

Email: _____

Emergency Contact: *In case we are unable to reach a parent please provide an alternative emergency contact.*

Name: _____ Phone Number: _____

Insurance Information:

Policy Holder: _____

Insurance Company _____

Policy ID Number _____

Family Physician: _____

Policy Holders Date of Birth _____

Employer _____

Group Number _____

Does your insurance require referral? YES / NO

Athletes Medical History:

Does the athlete have any life threatening allergies? Yes / No : _____

Will the athlete need to take any medications during the season? Yes / No: please list: _____

_____

Does the athlete have any special medical conditions that I need to be aware of? Yes / No: please list:

_____

Parenets Signature _____ Date _____

St. Elizabeth HEALTHCARE
Sports Medicine

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

As parent/guardian of _____ ("the Student"), a student at - _____ in Ft. Thomas, Kentucky, who desires to participate in the following extracurricular athletic program of the School: ANY/ALL SPORTS , during the _____ school year. I understand that in the course of competing in the Program or Program-sponsored events the Student may require attention or assistance from an Athletic Trainer for illness or injury incurred while participating in such Program-sponsored sporting events. I understand that the School has arranged for St. Elizabeth Healthcare to provide such attention and assistance during certain Program-sponsored events. I, the undersigned, hereby authorize St. Elizabeth Healthcare to release all medical information about the Student obtained in the course of providing athletic training attention or assistance during Program-sponsored events to the School and its representatives including, but not limited to, coaches, for the purpose of making determinations regarding the continued participation of the Student in the Program or Program-sponsored sporting events.

I understand that I have the right to revoke this authorization at any time except to the extent St. Elizabeth Healthcare has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to St. Elizabeth Healthcare.

I also understand that when information is used or disclosed based on an authorization; the information may be re-disclosed by the recipient and no longer protected by the Standards for the Privacy of Individually Identifiable Health Information.

This authorization is only good for the school year in which it is completed.

I understand that I have the right to refuse to sign this authorization. I further understand that such refusal may result in the Student's being ineligible to participate in the School's sporting activities.

_____ Student's Name

_____ Street/box number

_____ Student's Date of Birth

_____ City, State, Zip Code

_____ Student's Signature (required if student is 18 or over or will turn 18 before season ends)

_____ Student's Telephone Number

_____ Name of Parent or Guardian

_____ Date

_____ Signature of Parent or Guardian

_____ Relationship to Student (Parent, Guardian, etc.