

LEXINGTON HIGH SCHOOL SPORTS HEALTH FORM

EMERGENCY CONTACT INFORMATION

(Please Print)

Athlete's Full Name _____ Cell Phone _____

Sex _____ Age _____ Date of Birth _____ SS# _____ Grade _____ School Year _____

Mailing Address _____ City _____ Zip _____

Home Phone _____

Mother's Name _____ Phone _____ Employer/Occupation _____

Father's Name _____ Phone _____ Employer/Occupation _____

In an EMERGENCY, if parents cannot be contacted, notify:

Contact 1 _____ Phone _____ Contact 2 _____ Phone _____

Family Doctor _____ Phone _____ Family Dentist _____ Phone _____

Preferred Hospital _____ Glasses/Contacts _____

Allergies _____ Medications _____

Significant Medical History/Existing Conditions _____

HEALTH INSURANCE INFORMATION

Do you have health insurance? Y / N Do you have Medicaid? Y / N Medicaid Number _____

Name of Insurance Company _____ Mailing Address _____

Insured's Name _____ SS# _____ Policy # _____

Does your insurance plan require you to be seen by your primary care physician before being seen by a specialist? Y / N

Does your insurance require a second opinion before surgery? Y / N

Lexington School District 1 carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay secondarily to the athlete's primary health insurance. In the event of injury while participating as a part of a SCHSL sanctioned sports team representing Lexington High School, the athlete should seek the attention of a staff athletic trainer as soon as possible. The athletic trainer will complete the top portion of the insurance claim form. The parent will complete the remainder of the claim form, follow the attached directions, and mail the completed form to the insurance company. *Please note the claim must be filed within 90 days of injury.****

ACKNOWLEDGEMENT OF RISK & DUTY TO REPORT INJURY

My child and I have read and understand the concussion fact sheet, the LHS Concussion Management Plan, and the information on proper tackling technique (football only) attached to this document. We understand and accept the risk involved in athletic participation and in the travel required for that participation. We understand that it is his/her responsibility to report all injuries and illnesses to the school's staff athletic trainers immediately.

Parent's Signature _____ *Date* _____

PERMISSION TO PARTICIPATE/CONSENT FOR MEDICAL TREATMENT/RELEASE OF INFORMATION

As parent/legal guardian of the above named student, I give permission for him/her to participate in athletics, travel with his/her team to events, and for the physical evaluation for participation. I understand that the physical evaluation required for participation is simply a screening evaluation and not a replacement for regular healthcare. I give consent for athletic trainers, coaches, and physicians to use their own judgment in securing medical aid and ambulance service when the parent cannot be reached. In the event of an accident requiring immediate medical attention, I hereby grant permission to physicians, athletic trainers, and/or appropriate healthcare professionals to attend my child. It is understood that the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I give permission for my child to be evaluated and treated by the school's athletic training staff and/or team physicians if he/she is injured while participating as an athlete at Lexington High School. We authorize the school's athletic training staff to be given medical information concerning my child by a physician. Likewise, the athletic training staff may release medical information to physicians, coaches, nurses, administrators and faculty at Lexington High School, as they deem appropriate.

Parent's Signature _____ *Date* _____