



MEDICAL INFORMATION

The undersigned hereby authorize the University to provide first aid and, if necessary, secure emergency medical treatment for the Participant. The space below contains any allergies, required medications, special medical conditions, medical insurance information, and any other pertinent medical information regarding the Participant.

*Allergies: _____

*Medications: _____

*Special Conditions: _____

Name of Insurance Carrier: _____

Policy Number: _____

Has participant tested Positive for Covid-19, in the past 90 days? ___yes ___no

Has participant received the Covid-19 Vaccine? ___first dose ___second dose ___none

If yes, which: _____Pfizer _____Moderna _____Johnson & Johnson

In the event of an emergency, please contact the following person:

Name: _____

Daytime Phone Number: _____ Evening Phone Number: _____

The undersigned acknowledge and agree that the University is permitted to perform first aid and/or obtain emergency care for the participant if necessary and shall have no obligation to contact the above-referenced person in the case of an emergency but will make reasonable efforts to contact this person in the event of an emergency.

**Please note that in order for the University's Athletic Training staff to provide advanced medical treatment (ankle taping, etc.) the participant MUST have a signed doctor's (MD or DO) order by the participant's practicing physician in order to comply, as well as bringing their own necessary supplies.*

The undersigned certify that the foregoing medical information is correct, and that this consent and information is being voluntarily provided to the University.

Participant Signature

Date

Parent/Guardian Signature (if applicable)

Date