

**SENECA VALLEY SCHOOL DISTRICT  
STUDENT HEALTH RECORD AND EMERGENCY PROCEDURES**

*(This form must be filled out in duplicate)*

**PERSONAL**

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_  
Last First MI

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_\_\_ CITY OF BIRTH \_\_\_\_\_ STATE \_\_\_\_\_

PARENT'S NAME(S) \_\_\_\_\_

GUARDIAN \_\_\_\_\_ INSURANCE TYPE \_\_\_\_\_ POLICY # \_\_\_\_\_  
(List step-parents here)

FAMILY PHYSICIAN \_\_\_\_\_ PHONE # \_\_\_\_\_

HOW LONG HAVE YOU PLAYED ORGANIZED SPORTS? \_\_\_\_\_

HAVE YOU PLAYED IN THIS SCHOOL DISTRICT BEFORE? **YES NO** WHAT SPORTS? \_\_\_\_\_

LIST ANY ILLNESSES THAT YOU HAVE HAD IN THE LAST 4 MONTHS \_\_\_\_\_

**PAST MEDICAL HISTORY**

- |                                         |     |    |                                                |     |    |
|-----------------------------------------|-----|----|------------------------------------------------|-----|----|
| 1. Have you ever had a head injury?     | Yes | No | 10. Have you ever suffered a dislocation?      | Yes | No |
| 2. Have you ever had a neck injury?     | Yes | No | 11. Have you ever had emergency care?          | Yes | No |
| 3. Are you allergic to any medications? | Yes | No | 12. Are you currently under a doctor's care?   | Yes | No |
| 4. Do you have lower back problems?     | Yes | No | 13. Do you regularly take medications?         | Yes | No |
| 5. Have you been knocked out? Times?    | Yes | No | 14. Do you wear glasses or contact lenses?     | Yes | No |
| 6. Have you had any broken bones?       | Yes | No | 15. Have you had any surgical operations?      | Yes | No |
| 7. Have you had a knee injury?          | Yes | No | 16. Have you ever been hospitalized?           | Yes | No |
| 8. Have you ever had a severe sprain?   | Yes | No | 17. Do you have asthma?                        | Yes | No |
| 9. Are you allergic to bee stings?      | Yes | No | 18. Do you have diabetes? If so, Type I or II? | Yes | No |

***IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, PLEASE LIST ON BACK OF THIS FORM AND PROVIDE DETAILS!!***

**EMERGENCY PROCEDURES**

Dear Parents or Guardians,

In order to facilitate matters in the emergency room at our local hospital or at any hospital that your son or daughter may need emergency care, please sign the consent portion below.

The following are the reasons for the consent form:

1. Doctors and nurses in an emergency room cannot administer treatment or care to the student-athlete until the parents are contacted and give their consent.
2. Parents cannot be immediately contacted due to work or other duties that take the parents away from the home.

The trainer/student-trainer/coach assures that your son or daughter will receive the best treatment available.

In case of emergency, I \_\_\_\_\_, give my consent to the hospital or physician to  
(Parent's/guardian's signature)

perform or administer emergency care and treatment to my son or daughter, \_\_\_\_\_.  
(Student Athlete's name - printed)

**Mother**

**Father**

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Hospital Preference 1 \_\_\_\_\_

2 \_\_\_\_\_

Emergency Number if parents/guardians cannot be reached: Name \_\_\_\_\_ Phone # \_\_\_\_\_

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