

EMERGENCY MEDICAL INFORMATION AND RELEASE

Please provide us with your child's insurance information:

Medical Insurance Carrier: _____

Policy#: _____

Group#: _____

Subscriber's Name: _____

Address: _____

Physician's Name: _____

Phone #: _____

In case of accident or injury, I give my permission for my child to receive immediate/necessary medical treatment.

Parent/Guardian's Signature _____ **Date:** _____

**Town of Ludlow Recreation Athletics Program
SPORTS HEALTH QUESTIONNAIRE**

(This form will only be kept by the coach in case of medical attention/emergency)

Student's Name: _____

Grade: _____

MEDICAL HISTORY:

1. Date of last physical: _____

2. Since his/her last physical has he/she had:

- | | | |
|--|-----------|----------|
| a) Any injuries requiring medical attention? | Yes _____ | No _____ |
| b) Any illness lasting more than 1 week? | Yes _____ | No _____ |
| c) Any new medications? | Yes _____ | No _____ |

3. Does he/she have any allergies that require medication? Yes _____ No _____

4. Does he/she suffer from asthma? Yes _____ No _____

5. Does he/she suffer from epilepsy? Yes _____ No _____

6. Does he/she suffer from diabetes? Yes _____ No _____

7. Is he/she allergic to bee stings or flying insects? Yes _____ No _____

If yes, does he/she have an emergency treatment plan in place? Yes _____ No _____

8. Does he/she have any physical limitations? Yes _____ No _____

If yes to any of the above, please describe:

I have received and read a "Fact Sheet for Parents" regarding concussion information.

(Parent/Guardian Signature)

(Cell/Home Phone)

(Work phone)