The SEED School of Washington, D.C. Athletic Department

Athlete Data and Emergency Treatment Information

Name (Last, First, MI)_____ SEED Student ID#_____

Street_____ City_____ State_____ Zip_____

Gender ☐ Male ☐ Female Date of Birth_____ Grade_____

School_____ School Year_____

Emergency Contact-Please provide at least 2 Contacts (*Parent/Guardian should be listed first as Primary Contact)

Name	Relationship	Home	Work	Mobile

Insurance & Billing

Insurance Co._____ Policy #_____ Insurance Co. Phone_____

Policy Holder's Name_____ Effective Date_____

Do you have any of the following conditions (check all that apply)?

☐ Anemia ☐ Asthma_____(Inhaler Type) ☐ Sickle Cell / Sickle Cell Trait ☐ Diabetes

☐ Epilepsy ☐ High Blood Pressure ☐ Previous Concussion/Head Injury; if yes, date? _____

☐ Allergies Other_____

Do you wear contacts or glasses? ☐ Contacts ☐ Glasses

When was your last tetanus booster? Month/Year_____

List all medications currently used including prescribed, over the counter and rescue inhalers _____

Should it become necessary for this student to require medical treatment while participating in an interscholastic athletic event, trip or practice session, I hereby authorize the SEED School of DC health care providers (athletic trainers, team/game physicians and emergency medical technicians (EMT's)) to provide athletic medical care to my child and/or obtain appropriate medical services. Furthermore, if SEED personnel are unable to reach those designated above, I give my consent to the SEED athletic health care providers to take my child to a hospital, emergency care center or available physician.

Signature_____ **Date**_____

(Parent, Guardian or Student 18yrs+)

For Office Use Only:

Date of DC Universal Health Certificate (Physical)_____ AT/SC Initials:_____