Student Information:

Last Name _____ First Name _____Middle Initial_____

Sport/(s) _____ Grade _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone: _____ Student Cell Phone: _____

Parents Information:

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Name: _____

Address: _____

_____

Home Phone _____

Work Phone: _____

Cell Phone: _____

Email: _____

Emergency Contact: *In case we are unable to reach a parent please provide an alternative emergency contact.*

Name: _____ Phone Number: _____

Athletes Medical History:

Does the athlete have any life threatening allergies? Yes / No : _____

Will the athlete need to take any medications during the season? Yes / No: please list: _____

_____

Does the athlete have any special medical conditions that I need to be aware of? Yes / No: please list:

_____

AUTHORIZATION FOR TREATMENT & RELEASE OF HEALTH INFORMATION

As (please specify) parent/guardian of _____ (the "Student"), a student at _____ School (the "School") in Fort Thomas, Kentucky, who desires to participate in extracurricular athletic program(s) of the School (the "Program"), I understand that in the course of competing in the Program or Program-sponsored events the Student may require attention or assistance from an athletic trainer for illness or injury incurred while participating in such Program sponsored sporting events. I understand that the School has arranged for St. Elizabeth Healthcare to provide such attention and assistance during certain Program-sponsored events and I authorize Student to receive such attention and assistance. I, the undersigned, hereby authorize St. Elizabeth Healthcare to release all necessary medical information about the Student obtained in the course of providing athletic training attention or assistance during Program-sponsored events to the School and its representatives including, but not limited to, coaches, athletic director, team and/or family physician, for the purpose of making determinations regarding the continued participation of the Student in the Program or Program-sponsored sporting events.

I understand that I have the right to revoke this authorization at any time except to the extent St. Elizabeth Healthcare has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to St. Elizabeth Healthcare. I also understand that when information is used or disclosed based on an authorization, the information may be re-disclosed by the recipient and no longer protected by the Standards for the Privacy of Individually Identifiable Health Information.

This authorization shall expire at the end of the Program's season.

_____ _____
Student's Name Street/box number

_____ _____
Student's Date of Birth City, State, Zip Code

_____ _____
Student's Signature (required if student is 18 or over or will turn 18 before season ends) Student's Telephone Number

_____ _____
Name of Parent or Guardian Date

_____
Signature of Parent or Guardian

_____
Relationship to Student (Parent, Guardian, etc.)