

Athletic Camp/Clinic Sports Medicine Information Sheet

Please provide the following medical information for your child:

Primary emergency contact (Name, relationship, phone number)

Name _____
Relationship _____
Phone Number _____

Secondary emergency contact (Name, relationship, phone number)

Name _____
Relationship _____
Phone Number _____

Allergies (medication, food, bee sting, poison ivy, etc.)

Please describe the nature of the reaction (rash, hives, difficulty breathing, etc.)

Injury history (eg. recent sprains, fractures):

Medical conditions (eg. asthma, diabetes, cardiac disorders, seizure disorders)

Medications currently taking

Date of last tetanus shot (month/year)
