CoxHealth

EMERGENCY INFORMATION

Cox Monett Rehabilitation and Sports Medicine Services

PLEASE USE THE ATHLETE'S FULL LEGAL NAME Grade_____

Athlete's Name_____Birthdate_____/_____/_____Age____

Home Address_____ Phone(___) _____Sport(s)_____

Insurance_____

Primary Care Physician_____Dentist_____

Mother/Guardian Name _____ Home Phone(___)_____Work (___)_____Cell(___)_____

Father/Guardian Name_____ Home Phone(___)_____Work (___)_____Cell(___)_____

In the case of an emergency and a parent/guardian cannot be contacted, please notify:

Name_____Address_____

Relationship_____Cell Phone(___)_____HomePhone(___)_____WorkPhone(___)_____

Known Allergies_____

Known Medical Conditions_____

_____

Current Medications_____

Dislocations/Fractures/Surgeries_____

_____

If currently under the care of a physician, please explain_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize any medical provider of my son/daughter listed above, associated with his/her school/organization/team, including Cox Sports Medicine, Physicians, Athletic Trainers, and other Medical Providers, to use and disclose the athlete's clearance and health records, health status, information, recommendations, and emergency medical treatment to the athlete's: Coaches, Athletic Director, School Administrators and Medical Personnel.

EMERGENCY SERVICE AGREEMENT
I give my consent for COXHEALTH ATHLETIC TRAINERS of COX MONETT REHABILITATION SERVICES to provide all necessary medical aid and ambulance service to my son/daughter in the absence of my presence. I understand that the medical personnel of COX MONETT REHABILITATION SERVICES will perform only those procedures that are within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. Furthermore, I understand that I will be notified immediately if any medical emergency occurs. Lastly, I give consent for my son/daughter to participate in ImPACT ® Concussion Management Program with initial baseline testing (non-invasive) and subsequent testing if a concussion is suspected.

HOSPITAL OF CHOICE: _____ (COX MONETT/SPFD, MERCY, FREEMAN, etc.)

I HAVE READ ALL SECTIONS ON THIS PAGE, FULLY UNDERSTAND THEIR TERMS, UNDERSTAND THAT REFUSAL TO SIGN MAY AFFECT MY SON/DAUGHTERS ABILITY TO PARTICIPATE IN ATHLETICS.

THIS DOCUMENT WILL BE VALID FOR THE ENTIRE SCHOOL YEAR THAT PROCEEDS FROM THE SIGNED DATE.

X_____ X_____ DATE SIGNED: ____/____/_____

PARENT/GUARDIAN'S **PRINTED** NAME PARENT/GUARDIAN'S SIGNATURE

REV 5/2021