# Bishop England Sports Medicine

Rehabilitation Centers
RCC
of Charleston

## EMERGENY RESPONSE FORM

**LAST NAME**: ______________________________________ **SPORT**: _______________________________

**FIRST NAME**: _____________________________________ **SPORTS 2 & 3**: _______________________________

**GRADE**: $7^{TH}$ $8^{TH}$ $9^{TH}$ $10^{TH}$ $11^{TH}$ $12^{TH}$ **SCHOOL**: _______________________________________

**BIRTH DATE**: _____/_____/_____ ____ M ____ F

**ADDRESS**: ________________________________________ **CITY**: ______________________ **ZIP**: _________________

**HOME PHONE NUMBER(s):** ________________________________ / ___________________________________

**PARENTS/LEGAL GUARDIAN**

**MOTHER'S NAME**: ____________________________________ **WORK/CELL NUMBER**: ________________________

**FATHER'S NAME**: _____________________________________ **WORK/CELL NUMBER**: ________________________

**SECONDARY EMERGENCY CONTACT**

**NAME**: _________________________________________ **RELATIONSHIP**: ____________________________

**PHONE NUMBER**: _______________________________

**ALLERGIES**: _________________________________________________________________________________________

**SPECIAL MEDICAL CONCERNS**: ______________________________________________________________________

**NAME OF INSURANCE CO.:** __________________________________________________________________________

**POLICY #:** ____________________________________________________ **DATE OF POLICY:** _____/_____/_____

**FAMILY PHYSICIAN**: _________________________________________ **PHONE NUMBER**: ____________________

As the parent(s) or legal guardian(s) of (Name of athlete) ________________________________________, I give my consent for his/her practice and play in athletic events. I verify that my child has adequate health insurance through the above-mentioned insurance company. I do not hold the school responsible in any way whatsoever. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history filled out on the physical form is accurate to the best of my knowledge.
My signature also verifies that my child and I have completely read and understand this handbook.

I completely understand the above and authorize my consent:

Signed ___________________________________________________ Date: ____________________________
(Father, Mother, or legal guardian)

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# Risk Acknowledgement

**WARNING:** Although participation in supervised interscholastic athletics and activities may be one of the least hazardous things in which any student will engage in or out of school, BY ITS NATURE, PARTICIPATION IN INTERSCOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC, INCLUDING PERMENENT PARALYSIS FROM THE NECK DOWN OR DEATH. Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate risk.

Participants can, and have the responsibility to, help reduce the chance of injury. PARTICIPANTS MUST OBEY ALL RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACH AND ATHLETIC TRAINER, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.

By signing this statement, we acknowledge that we have read and understand this warning.

_______________________________ ______/______/______ ____________________________

STUDENT-ATHLETE'S SIGNATURE DATE PARENT/GUARDIAN SIGNATURE

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, nurse, physical therapist, or athletic trainer who has attended me/my child, or any hospital or infirmary at which I have been treated or admitted, to furnish RCC, through our referral physician network, Greg Banks, ATC copies of any information, notes, or hospital records concerning attendance upon, treatment, care, or confinement of the student-athlete undersigned. This authority extends to all records, including history, diagnostic tests, copies of findings, x-rays, examinations, consultation, opinions of physicians and surgeons or other medical personnel who may have any knowledge of any condition, examination or treatment of the student-athlete undersigned.

Athlete's Name: ________________________________________ Date of Birth: ______/______/______
(PLEASE PRINT)

Social Security Number: _________-______-____________ Sport: ___________________________

_______________________________ ______/______/______ ____________________________

STUDENT-ATHLETE'S SIGNATURE DATE PARENT/GUARDIAN SIGNATURE