MEDICAL INFORMATION SHEET

Athlete Information

Full Name: _____Sport:_____

Age: _____ Date of Birth: _____ Email Address_____

Address: _____City: _____Zip:_____

Cell Phone: _____School Phone: _____

Emergency Contact Person: _____

Relationship to Athlete: _____Phone:_____Cell:_____

Address: _____City:_____Zip:_____

Additional Emergency Contact Person: _____

Relationship to Athlete: _____Phone:_____Cell:_____

Address: _____City:_____Zip:_____

Health Insurance: _____ ID:_____

Medical Information

Allergies: _____

Medical Illnesses: _____

Medications: _____

(ANY MEDICATIONS TO BE TAKEN DURING COMPETITION REQUIRE A PHYSICIAN'S NOTE)

Previous head/neck/back injury: _____

Previous heat-related problems: _____

Previous significant injuries: _____

Other necessary medical information: _____

Consent for Athletic Conditioning, Training, and Healthcare Procedures

I hereby agree to participate in the school's athletic conditioning and training program and to receive any necessary health care treatment; including first-aid, diagnostic procedures and medical treatment that may be provided by physicians, physical therapists, nurses, and other health care providers, including Foothills Physical Therapy Center's Athletic Trainers. Foothills Physical Therapy Center has my permission to release information regarding my athletic injuries to school coaches, staff and Medical personnel.

Consent for Cognitive Testing and Release of Information

I give my permission to have a baseline and, in the event of injury, a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) test administered at Johnson University, Foothills Physical Therapy or other suitable location.

I also give my permission for Johnson University and/or the Athletic Trainer to release the ImPACT results to the Knoxville Orthopaedic Clinic treating physician.

Signature: _____**Date**:_____