2 SIDED FORM

Plymouth-Canton Educational Park Medical Emergency Form

Student Name (last, first):_____

Sport this season:_____

RETURN THIS FORM WITHIN 1 DAY OF START OF SEASON TO YOUR COACH.

Athlete's last name:	Athlete's first name:	Parent/s names:
Parent/s home phone(s):	Parent/s cell phone(s):	Parent/s work phone(s):
Primary Physician:	Physician Phone Number:	Physician Address:
Insured's name:	Insurance Provider:	Group/Contract Number:
Emergency Contact Name:	Emergency Contact 2 Relationship:	Emergency Contact Phone:
Emergency Contact 2 Name:	Emergency Contact 2 Relationship:	Emergency Contact 2 Phone:
Any known allergies:	Any medical conditions or injuries:	Medical devices carried:
Other Relevant Medical Information:		

I, _____, the parent/guardian of _____(student name) recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances.

I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA, Canton High School administrative and clerical staff, coaches, athletic trainers, and emergency medical staff of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics and for determining proper medical treatment and care.

_____ _____ _____

Parent Signature Date Parent Printed Name

RETURN THIS FORM WITHIN 1 DAY OF START OF SEASON TO YOUR COACH.

Form is 2-sided

Plymouth-Canton Educational Park Athletics Concussion/Head Injury History Form

Student Name (last, first):_____

Has student athlete ever experienced a traumatic head injury? Yes ___No___

Has student athlete ever received medical attention for a head injury? Yes ___No___

Was the student athlete diagnosed with a **concussion by a medical professional** (MD, DO, PA, NP)? Yes ___No___

If the student has been diagnosed with a concussion, please list date(s) (mm/yy): _____

If the student has been diagnosed with a concussion, please describe circumstances:_____

_____

_____

Please list duration of symptoms such as headache, difficulty concentrating, fatigue, and length of school missed due to these symptoms, if applicable. _____

_____

_____

All students who have a suspected head injury during the athletic season must follow the Michigan High School Athletic Association (MHSAA) "return to participation" protocol. Read more by visiting www.MHSAA.com and clicking on "Health and Safety."

_____ _____ _____

Parent Signature Date Parent Printed Name

RETURN THIS FORM WITHIN 1 DAY OF START OF SEASON TO YOUR COACH.

Form is 2-sided