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COLLEGE OF MARIN

PHYSICAL EDUCATION

Emergency Information

☐Male ☐Female Sport:_____

☐Fall ☐SpringYear:_____ Eligibility: ☐1st year ☐2nd year

Note: This information will be used only in the event of any emergency. Your emergency contact person will not be notified unless you give your consent or are incapacitated and are unable to make medical decisions for yourself.

Name:_____Birthdate:_____Age:_____

Local Address:_____City:_____State:_____Zip:_____

Cell Phone _____ Work Phone _____ Home Phone _____

Email Address _____

Are you covered under a health insurance policy? ☐Yes ☐No Is this policy an ☐HMO or a ☐PPO?

List any drugs or medications to which you have an allergy (e.g. penicillin):_____

Name of the Policy Holder: _____

Name of Insurance Company_____

Policy Number:_____Group Number:_____

IN CASE OF EMERGENCY

1. Name:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone _____ Work Phone _____ Home Phone _____

2. Name:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone _____ Work Phone _____ Home Phone _____

ATHLETIC TRAINING ROOM CONSENT TO TREAT:

- I hereby authorize the Certified Athletic Trainer(s) and sports medicine staff acting on behalf of COM to evaluate and treat any injury/illness that occurs as a re?ult of my participation in in ercollegiate athletics at COM.Thisincludesanyandallreasonableand necessarypreventativecare,treatment,andrehabilitationfor theseinjuries/illnesses.
- I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission by a Physician, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment. The Physician has the FINAL authority regarding participation status followinginjury/illness.
- I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and the Certified Athletic Trainer. I also agree to adhere to the establishedinjurymanagementguidelinesincludingrehabilitationandreassessmentbeforelamreleasedto return to fullparticipation.
- This authorization expires Two (2) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletictraining room.

Signature:_____Date:_____

Student (Parent or Guardian if under 18 years of age)