LCMC Health

ATHLETE INFORMATION CARD

FULL NAME: _____ DOB(MM/DD/YYYY): _____
ADDRESS: _____ CITY:_____STATE: _____ ZIP: _____
HOME PH #: (____)_____ CELL PH #:(____)_____
GENDER: MALE_____ FEMALE_____ GRADE: _____
SPORT/SPORTS PLAYED: _____ HT: ____ WT: ____

EMERGENCY CONTACT INFO

EMERGENCY CONTACT #1:
RELATIONSHIP: MOM____DAD_____OTHER (_____)
FULLNAME:_____ DOB:_____
ADDRESS: _____ CITY:_____ STATE: ____ ZIP: _____
HOME PH #: (____)_____ CELL PH #:(____)_____
WORK PH #:(_____)_____

EMERGENCY CONTACT #2:
RELATIONSHIP: MOM____DAD_____OTHER (_____)
FULL NAME:_____ DOB:_____
ADDRESS: _____ CITY:_____ STATE: ____ ZIP: _____
HOME PH #: (____)_____ CELL PH #:(____)_____

HEALTH INSURANCE NAME: _____ PH #: _____
NAME OF INSURED:_____
I hereby release the above listed information to the sports medicine team. I agree to allow sharing of medically necessary information in regards to approved/necessary care.

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

LCMC Health

Consent to Treatment and Waiver of Liability Form

I, _____ (parent/guardian) of _____ (student/athlete), understand that LCMC Sports Medicine (Children's Hospital, New Orleans East Hospital, Touro Infirmary, West Jefferson Medical Center, and University Medical Center) provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of _____ (School/Event). In case of emergency or accident on the school grounds or during any school activity involving the student designated below, which in the opinion of school authorities or personnel of LCMC Sports Medicine requires immediate medical attention, I hereby grant permission to such school authorities and LCMC Sports Medicine personnel to render medical care and to obtain the services of qualified medical personnel to treat the condition unless I am present and request otherwise or until revoked.

I also hereby release and agree to hold harmless all entities of LCMC Sports Medicine, their employees and agents, including, but not limited to, the Athletic Trainers from any and all liability in case of accident, injury, damage or other mishap in connection with all medical services or athletic trainer services they provide the student.

_____

Student Name

_____ _____

Student Signature Date

_____

Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date

_____

Phone Number

CONSENT FOR BASELINE COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____,
born (date of birth) _____, to have a baseline ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered at
_____(School).
I understand that my child may need to be tested more than once, depending upon the results of the test. I understand there is no charge for the testing.

_____ (School) may release the ImPACT test results to my child's primary care physician, neurologist, other treating physician, or any licensed healthcare professional as requested when/if needed.

Signature of parent/guardian _____

Name of parent/guardian _____

Date _____

Student's home address (street address, city/state/zip)

_____

Parent or guardian phone numbers:

Home _____ Preferred contact number: Home Work Mobile

Work _____ Preferred time to call (if necessary): _____ am/pm

Mobile _____