



# Medical Card for Athlete

MCP5 Form 560-30  
October 2010

Interscholastic High School Athletics  
MONTGOMERY COUNTY PUBLIC SCHOOLS • Rockville, Maryland 20850

**INSTRUCTIONS:** This card should be kept on file in the medical kit for each sport. It should accompany the athlete to the doctor or hospital when medical attention is required.

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**If parent cannot be reached, person to be contacted in case of emergency**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

over

## MEDICAL CARD FOR ATHLETE

Family Physician: \_\_\_\_\_ Physician #: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medicine Administered on the Field: \_\_\_\_\_

**INSURANCE INFORMATION:**  
Does your son/daughter have medical insurance?  Yes  No  
If Yes, Name of Insurance Company: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RELEASE FOR TREATMENT:**  
I hereby give permission to the attending physician or hospital to administer appropriate medical treatment in the event I cannot be reached.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_

**This card must be kept on file in the medical kit for each sport and should be available at all practices and contests. It must accompany the athlete to the doctor or hospital when emergency medical attention is required.**