

**Minority Coaches Association of Georgia  
Emergency Permission to Treat Form  
Medical History**

**Players's Name:** \_\_\_\_\_

**Event:** 2016 Football Academy

**EMERGENCY PERMISSION TO TREAT FORM**

I hereby grant permission for the above named athlete to receive treatment which is deemed necessary for a condition arising during the showcase or combine, including but not limited to, medical or surgical treatment recommended by a medical doctor. I understand that reasonable efforts will be made to contact me prior to the above named athlete receiving such treatment.

► **Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

MEDICAL HISTORY (to be completed by Guardian)

**Yes No** Has anyone in athlete's family died suddenly before the age 50?

**Yes No** Has athlete ever felt dizzy or passed out during exercise?

**Yes No** Does athlete have asthma, hay fever or coughing spells?

**Yes No** Has athlete ever had a concussion (gotten knocked out)?

**Yes No** Has athlete ever suffered heat related illness (heat stroke)?

**Yes No** Does athlete have a history of convulsions or seizures?

**Yes No** Does athlete have any known past illness of more than one week's duration?

**Yes No** Does athlete have any permanent deformity or disability?

**Yes No** Does athlete have only one of any paired organ (kidneys, eyes, testicles, etc)?

**Yes No** Has athlete ever had surgery of any type?

Please explain further on any "yes" answers \_\_\_\_\_

**Yes No** Has athlete ever broken a bone or injured a joint? If yes, what body part, what type of injury and what age?

**Yes No** Does athlete see a doctor regularly for a problem? What \_\_\_\_\_

**Yes No** Has athlete been prescribed an inhaler or EpiPen? Why \_\_\_\_\_

**Yes No** Is athlete presently taking medication? What \_\_\_\_\_

**Yes No** Is athlete allergic to any medications? What \_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_

I certify that the information provided in this medical history form is true and accurate with regard to the athlete named herein.

I also give my permission for the above named athlete's medical providers and personnel (physicians, physical therapists, athletic trainer, etc) to discuss and share with the Minority Coaches Association of Georgia personnel (coaches, athletic trainers, etc) any and all medical information pertinent to the above named athlete's health, medical condition, treatment, rehabilitation and return to participation in the showcase/combine, and further to complete the medical examination form. I further agree that it is necessary for the above name athlete to undergo a medical examination to determine whether (he/she) is or is not medically qualified to participate in the above named showcase/combine and I consent to such an examination.

► **Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

► **Insurance Company Name** \_\_\_\_\_ **Policy#** \_\_\_\_\_