SANTA ROSA JUNIOR COLLEGE

Sport: ☐Men ☐Women _____
Fall: ☐Spring ☐ Fall Year: _____
Eligibility: ☐GS ☐RS ☐1st year ☐2nd year

Emergency Information Card

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: _____ Birth date: ____/____/_____ Age:_____ SID:_____

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? _____

Name of the Policy Holder: _____

Name of Insurance Company: _____ Policy Number: _____

Group Name: _____ Group Number: _____

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

_____

In Case of Emergency Notify:

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 Trainers and sports medicine staff acting on behalf of SRJC to evaluate and treat any injury/illness that occurs as a result of my participation in intercollegiate athletics at SRJC. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/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 the Team Physician, his/her delegate, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment. *The team physicians of SRJC have the FINAL authority regarding participation status following injury/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 established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.
- This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

Signature _____ **Date** ____/____/_____

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