2023-24 ESDAA Tournament Medical Form Varsity Sports- Girls

Medical History is required to attend any tournament.

Student: _____ Age: _____ DOB: _____

Parent/Guardian: _____

Address: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Describe any physical/medical issues: (i.e.: seizures, diabetes, etc.) _____
_____

Date of last tetanus shot: _____
List any allergies to food or medication: _____
_____

List any medication to be given. Include the drug, dosage, and reason for medication. (Also, please fill out the attached medication permission form(s).)
_____

_____

Private Physicians' Name: _____ Phone: _____

Medical Insurance Co: _____

Medical / Medicaid Insurance Policy Number: _____

Medical Insurance Policy Holder: _____

I, _____, hereby give permission for my child to receive medical treatment at any time due to an emergency while present at any of the following:
(Insert Tournament name and date)

- Volleyball Tournament Friday, 10/27/23-Sunday, 10/29/23 New Jersey School for the Deaf
- Basketball Tournament- Friday 2/9/24- Sunday 2/11/24 Delaware School for the Deaf
- Track Tournament- Friday 5/10/24- Saturday 5/11/24 Maryland School for the Deaf

I accept all responsibility for medical, hospitalization, and liability that may arise from this tournament. I understand that any charges incurred for such treatment are my responsibility and agree to pay for any charges not covered by my insurance.

Parent/Guardians'
Signature: _____ Date: _____

Form Revised: 9/24

ESDAA Tournament Medication Permission Varsity Sports- Girls

I request and give permission for my child, _____, to receive the following medication during any of the following athletic contests/tournaments at: (Insert Tournament name and date)

- Volleyball Tournament Friday, 10/27/23-Sunday, 10/29/23 New Jersey School for the Deaf
- Basketball Tournament- Friday 2/9/24- Sunday 2/11/24 Delaware School for the Deaf
- Track Tournament- Friday 5/10/24- Saturday 5/11/24 Maryland School for the Deaf

(Please submit a separate sheet for each medication.)

Name of Medication: _____

Dosage: _____

Time(s) to be taken: _____

How it is administered: _____

I UNDERSTAND THAT I MUST SEND THE MEDICATION IN THE ORIGINAL LABELED CONTAINER. ALL STUDENTS ARE **SELF-DIRECTED UNLESS NOTED (can administer their own medicines with supervision.)** All of the above information is on the label on the container prepared by the pharmacist as prescribed by:

Name of Physician: _____

Telephone Number: _____

Physicians'
Signature: _____ Date: _____

Parent/Guardians'
Signature: _____ Date: _____

Please describe any allergies or health problems that your child has.

Form Revised: 9/23

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