

**STEP 4**

**EMU Athletic Training Department  
EMERGENCY NOTIFICATION**

**Athlete's Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Athlete's Primary Address (Campus/Local):**

EMU Dorm & Room #: \_\_\_\_\_

Street Address (if off campus): \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #s (Campus / Cell): \_\_\_\_\_ / \_\_\_\_\_

**Athlete's Secondary Address (Home):**

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

**Primary Emergency Contact: (Parent preferred)**

Name: Last \_\_\_\_\_ First \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Secondary Emergency Contact:**

Name: Last \_\_\_\_\_ First \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**MEDICAL ALERTS**

Please list any medical conditions, allergies and/or regularly taken medication that emergency medical personnel should be aware of:

Alerts/Allergies 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Medicines 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**CONSENT AUTHORIZATION AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I authorize the release of my medical records as may be requested by the certified staff members of Eastern Mennonite University's Athletic Training Staff and/or the Director of EMU Health Services. Information from these records will be used to provide appropriate care and to assist in medical eligibility decisions. All information will be considered confidential. All such records will be maintained in the athlete's permanent medical record files located in the office of the Head Athletic Trainer and the Director of Health Services.

\_\_\_\_ Yes, I agree to release needed records pertaining to my athletic participation.

\_\_\_\_ No, I wish my records to remain confidential with my physician.

\_\_\_\_\_  
(signature of athlete)

\_\_\_\_\_  
(date)

Mike Downey, MS ATC  
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Eastern Mennonite Univ.  
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Fax: 540-432-4443

**PERMISSION TO TREAT MINOR**

Student-athletes who are not 18 years of age must have their parents' permission to receive medical care.

I give permission to the certified athletic trainers and medical staff of Eastern Mennonite University as well as certified athletic trainers at host institutions to evaluate and treat my son/daughter. Every effort will be made to contact you and/or the person listed above on the Emergency Notification form prior to any medical services being rendered in an off-campus setting; however, emergency care will be provided as needed.

\_\_\_\_\_  
Signature of parent

\_\_\_\_\_  
Relationship to student-athlete

\_\_\_\_\_  
Date