Emergency Medical Treatment, Consent and Information

The following information will be used in the event that a parent / legal guardian is not available. The purpose of this information is to provide a quick reference for medical personnel should the need arise. Please fill out this form completely. If a particular question is not applicable write "none", n/a, or other appropriate comment otherwise none will be assumed. If additional space is needed, please use the back of this form or attach additional pages as needed. All information disclosed here will be treated as confidential. It will be the responsibility of the parent/legal guardian to notify the participant's coach and league/event officials if any information needs to be added, deleted, changed, or updated in any way.

ATHLETE INFORMATION			
Athlete's Name:	Nick Name:	Phone: ( )	
Address:	City:	State:	Zip:

PARENT OR GUARDIAN INFORMATION			
Father's Name:			
Address:	City:	State:	Zip:
Hm Phone: ( )	Daytime Phone: ( )	Email:	
Employer:			
Mother's Name:			
Address:	City:	State:	Zip:
Hm Phone: ( )	Daytime Phone: ( )	Email:	
Employer:			
Guardian's Name:			
Address:	City:	State:	Zip:
Hm Phone: ( )	Daytime Phone: ( )	Email:	
Employer:			

FAMILY MEDICAL INSURANCE			
Carrier:	Group:		
Policy #:	Group #:		
Policy Holder Name:			
Family Physician's Name:			
Dr's Address:	City:	State:	Zip:
Phone: ( )	Fax: ( )	Email:	

EMERGENCY MEDICAL INFORMATION
Preferred Hospital(s):
EMERGENCY CONTACT: ***Phone: ( )*** ***Relationship:***
Please list any medical conditions (allergies, asthma, etc.) And medications being taken by the participant named above. Please list any other information you may deem relevant, and helpful to emergency medical personnel: (please note if no information is given and the words "none" or "n/a" is not filled in then, "none" will be assumed.
Allergies:
Medical Conditions:
Other:

*I as evidenced below hereby grant permission for my child/ward to participate in any and all, _____TMF_____ (Torrington Warriors Youth Football and Cheer) program(s) event(s), including but not limited to, athletic, social and/or fundraising activities. I further consent to the administration of any and all medical treatment necessary to stabilize and or treat any medical condition or medical emergency to which my child/ ward is afflicted. I understand that this authorization is given prior to the need for medical care, but given in advance to avoid any unnecessary delay in emergency treatment which the attendant and/or medical professional may deem advisable in the exercise of their best judgment.

Print Parent/Legal Guardian Name ***Signature Parent/Legal Guardian*** ***Date***

The original Emergency Medical Treatment, Consent and Information form should travel with the coach and a copy should be kept at the administrative office of the sports organization. Due to privacy concerns, completed forms should be stored in a secure location with access restricted to those on a need to know basis for the purpose of medical care.

2024-2025 YOUTH PARTICIPANT MEDICAL HISTORY FORM

Special Note: This form must be completed thoroughly and honestly, and signed by the youth participant's parent or legal guardian. It is to be completed and dated after January 1, 2024. This form applies to the 2024 Fall – 2025 Spring season and needs to be submitted to your LOCAL Pop Warner organization. This form and its contents will be available to authorized Pop Warner personnel and kept confidential. **By signing this form, the parent or legal guardian agrees to the terms and conditions outlined below.**

Section I: POP WARNER AFFILIATION

League: _____ Association: _____

Section II: YOUTH PARTICIPANT INFORMATION (must match birth certificate)

Last: _____ First: _____ Middle: _____

Date of Birth:_____ Age: _____ Male ☐ Female ☐ Sport: Football ☐ Cheer/Dance ☐

Section III: PRIMARY AND SECONDARY CONTACT

Primary Contact: Parent or Guardian

Last: _____ First: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone No: _____ Alternate Phone No: _____

Email: _____ Relationship to Child: _____

Secondary Contact:

Last: _____ First: _____

Mobile Phone No: _____ Alternate Phone No: _____

Email: _____ Relationship to Child: _____

Section IV: INSURANCE INFORMATION

Primary Insurance Company: _____ Primary Group/Policy #: _____ / _____

Does primary insured have Medicaid? Yes ☐ No ☐ Does primary insured have Medicare? Yes ☐ No ☐

Family Doctor Name: _____ Doctor Phone No: _____

Section V: MEDICAL HISTORY OF THE YOUTH PARTICIPANT

Please identify and elaborate on any medical conditions which we should be aware (if none, write none):

_____

_____

_____

_____

2024-2025 YOUTH PARTICIPANT MEDICAL HISTORY FORM

Please list any medications currently being taken (if none, write none):

_____

_____

In the past 24 months, has the participant been tested, diagnosed and/or treated for a concussion: Yes ☐ No ☐

If yes, provide the specific date and detail on the diagnoses/treatment and the outcome:

_____

_____

List any known allergies (if none, write none):

_____

_____

Date of last Tetanus Toxoid Booster: _____

The purpose of the above information is to ensure that medical personnel have details of any issues which may interfere with or alter medical treatment.

Section VI: PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of serious injury, illness or death, and in consideration for Pop Warner Little Scholars, Inc. and its members accepting my child as a participant in its official programs, I consent to my child participating in Pop Warner tackle football, flag football, cheer and / or dance. Further, I hereby release, discharge, and otherwise indemnify Pop Warner, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my child as a result of participating in the Pop Warner programs.

My child has received a physical examination by a licensed health care provider within the past two years and has been found physically capable of participating in the sport of football and/or cheerleading & dance. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the programs. I give my consent to have an athletic trainer and/or licensed health care provider, including a medical doctor or dentist, provide my child with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

Signature of Parent/Guardian: _____ Date: _____

Torrington Warriors Youth Football and Cheer,
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form

I, _____ (athlete), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the organizations staff (e.g., coaches, team physicians, and athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My organization has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion) on what a concussion is and has given me an opportunity to ask questions. FACT sheets are different for Parents, Coaches, Players.
- I ACKNOWLEDGE THAT I HAVE READ THE FACT SHEET on the CDC website for Parents and Players.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician, athletic trainer, coach, parent volunteer, or official.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spirit line, wrestling, lacrosse, mixed martial arts, and rugby and cheer.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____

Date: _____

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: _____ Signature: _____

Date: _____