PLEASE RETURN FORMS TO THE ATHLETIC TRAINER ATTN: ZOE EICKHOLDT AT BETHESDA ON/BEFORE Monday, April 3, 2017

Dear Parent / Guardian: March 8, 2017

Enclosed you will find the physical packet that is required of all students attending Bethesda Academy for the 2017-2018 school year. If your child is interested in playing a school sport next year, we strongly recommend that you take advantage of the upcoming Pre-Participation Screening (PPS) that will be taking place on **FRIDAY- APRIL 7th, 2017**. **The screening will occur in the Bethesda gymnasium at 8:30am.** The PPS is being jointly conducted by Memorial Sports Medicine, Memorial Family Practice, Chatham Orthopedics, and Bethesda Academy athletic department. The cost of the screening is **$20.00 CASH ONLY**. A portion of the funds collected from the PPS will go directly to your school's athletic department to help defray costs for athletic training supplies. This screening will be valid through the end of the 2017-2018 school year and will be kept on file at the school and with the athletic trainer. Please note, SCISA recommends for a physical to be valid for the 2017-2018 school year it should be performed after April 1, 2016.

If your child will be participating in the PPS, please fill out the first 7 pages [Emergency Contact and insurance information with a copy of your insurance card, Permission and Medical Release Form, Heat and Humidity Policy, Concussion Policy, Pre-participation Physical Evaluation-History] completely as well as your name and DOB at the top of pages 8 and 9. It is extremely important that this packet is completed, signed by the parent and the student-athlete; and **returned by Monday, April 3rd, to the school office with $20 cash, Attn: Zoe Eickholdt**. Returning the packet by April 7th will expedite your child's PPS process and ensure that he gets through the screening in a timely fashion. Incomplete information or missing signatures will disqualify or delay your child from our screening process. This means that you will have to arrange for your son to receive a PPS/Physical by your own means.

If your child is unable to attend the screening on **April 7th,** you may have your child's physical completed by your personal physician. Please note that pages 1-7(including insurance card) need to be completed and signed by you and your son and pages 8-9 must be completed and signed by a Licensed Medical Physician or Doctor of Osteopathic Medicine. **All athletes participating in summer workouts must have completed physical packets prior to the first day of conditioning/workouts.**

The PPS on April 7th is not the same as a regular physical exam administered by your family physician. It is a screening to ensure that your child is medically eligible for participation. It does additionally meet Bethesda Academy's school and SCISA requirements. Memorial Sports Medicine recommends that every child receive a regular physical exam from his primary care physician to ensure general good health. ***If your child currently takes a prescription medication or has a medical condition, please have the treating physician send a clearance note stating your child is able to participate in athletics while under their care.*** Furthermore, if your child has any of the following conditions, they **MAY NOT** be cleared to participate in athletic activities until they receive a clearance letter from a primary care physician:

- Asthma, any diagnosed heart conditions, unusual or elevated Blood Pressure readings, history of diabetes or Sickle Cell Trait
- History of multiple concussions
- Athletes with certain prescription medications
- Any medical conditions in need of further medical review

We strongly encourage every student who is slightly interested in trying out for any sport to take advantage of this opportunity. If you have any questions about any part of the screening process or about athletic physicals in general, please feel free to contact Zoe Eickholdt, LAT, ATC at 248-821-1018 or athletic.trainer@bethesdaacademy.org. You may also contact the front office at 912-351-2055. Thank you for your cooperation in this matter and we look forward to working with your student-athlete this coming school year.

Sincerely,

Zoe Eickholdt, LAT, ATC
Memorial Sports Medicine Athletic Trainer

Coach Antwain Turner
Bethesda Academy Athletic Director

The following is a PPS checklist: FORMS MUST BE SIGNED, DATED AND COMPLETED AND RETURNED BY April 3rd

____MSM Emergency Contact & Insurance Information (pg 2)
____ **Copy of Insurance Card** (**Front/Back**) (pg 3)
____ MSM Permission & Medical Release (pg 4)
____ MSM Heat and Humidity Policy (pg 5 parents and student)
____MSM Concussion Policy (pg 6- parent and student)
____ Medical History (pg 7-filled out by parent)
_____ Physical Examination Form (pg 8- FILLED OUT BY MEDICAL PERSONNEL ONLY)
_____ Clearance Form (Pg 9- FILLED OUT BY MEDICAL PERSONNEL ONLY)
_____ $20 CASH ONLY Payment
_____ Name and DOB on top of pages 8 & 9

BETHESDA ACADEMY

Memorial Sports Medicine Experience Excellence.

EMERGENCY CONTACT & INSURANCE INFORMATION

Student's Name (Legal)_____,____ _____, _____
LAST FIRST MI

Social Security #_____-_____-_____ **D.O.B**_____/_____/_____ **2016-17 Grade Level:** _____

Address: _____, **GA** _____
STREET CITY ZIP

Student's Home Phone #: _____ **Student's Cell Phone #:** _____

Child Lives With: _____ Father _____Mother ____Both _____ Other: _____

Father/Guardian's Name: _____ **Home Phone #(**_____**)**_____**-**_____

Father/Guardian's Employer: _____

*Father/Guardian's Cell Phone # (*_____*)*_____*-*_____ *Work Phone # (*_____*)*_____*-*_____*ext*_____

Mother/Guardian's Name:_____ **Home Phone#(**_____**)**_____**-**_____

*Mother's Employer:*_____

*Mother/Guardian's Cell Phone # (*_____*)*_____*-*_____ *Work Phone # (*_____*)*_____*-*_____*ext*_____

Parent/Guardian contact e-mail address: _____

Emergency Contact & Relationship (must be 21 or older): _____

*Contact Home Phone # (*_____*)*_____*-*_____ *Contact Cell Phone # (*_____*)* _____*-* _____

Primary Physician: _____ **Office Phone # (**_____**)**_____**-**_____**ext**_____

INSURANCE INFORMATION

Primary Insurance Co: _____ **Name of Policy Holder:** _____

Policy #: _____ **Group #:** _____

Insurance Co. Phone # (_____**)**_____**-**_____**ext** _____

PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD

Medical Conditions: _____
Allergies: _____
Medications & Condition: _____

PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT ABSENCE

*I give permission for representatives of Bethesda Academy to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation and treatment by certified athletic trainers at away competitions.

Print Parent Name:_____ **Parent Signature:** _____

PLEASE ATTACH COPY

(FRONT/BACK) OF

STUDENT'S

INSURANCE CARD*

BETHESDA ACADEMY

Memorial Sports Medicine Experience Excellence.

School Year 2017-2018

PERMISSION & MEDICAL RECORD RELEASE FORM

Student's Name: _____

Last **First** **M.I.**

ASSUMPTION OF RISK AND PERMISSION TO TREAT

I am aware playing or practicing to play/participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play/participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social, and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play/participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold the Bethesda Academy, its direct and contracted employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Bethesda Academy activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and/or sickness occur to the participant listed above, and the participant is under the supervision of Bethesda Academy, and the participant's parent / legal guardian is unavailable to give his/her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to Memorial Health and Memorial Sports Medicine to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Memorial Health and/or Bethesda Academy financially responsible for any medical care given. An insurance policy may be available through the school for an additional cost.

I specifically acknowledge that **Football** and **Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports: Basketball, Baseball, Cheerleading, Lacrosse, Soccer, Softball, and Volleyball** which involve greater risk of injury that **non-contact sports: Bowling, Cross Country, Equestrian, Golf, Rowing, Swimming, Track & Field and Tennis.**

_____ ___/____/_____ _____ ___/____/____

Student's Signature Date Parent /Guardian Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

General Disclosure:

I hereby authorize Memorial Health and/or Memorial Sports Medicine Medical Personnel to release information from my medical records for the purpose of payment, treatment or operations to their Business Associate Partner (which includes; the Attending School's Coaching Staff and Administrators) and any Hospital in case of an Emergency Situation. This authorization shall be valid for the duration of the 2016-2017 school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Health and/or Memorial Sports Medicine discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

_____ ___/___/____ _____ ___/____/_____

Student's Signature Date Parent/Guardian Signature Date

HEAT & HUMIDITY POLICY

Heat and Humidity Awareness:

Bethesda Academy and Memorial Sports Medicine follows the policy issued by the High School Association of the State of Georgia. This statewide practice policy is for extremely high heat and humidity and list guidelines for monitoring the heat during sports that occur in the warmer months. This includes practices, games, and voluntary conditioning.

GUIDELINES FOR HYDRATION AND REST BREAKS:

- Rest time should involve both unlimited hydration intake (water or electrolyte drinks) and rest without any activity.
- For football, helmets should be removed during rest time.
- The site of rest should be a "cooling zone" and not in direct sunlight.
- When the WBGT reading is over 86:
    - Ice towels and spay bottles filled with ice water should be available at the "cooling zone" to aid the cooling process
    - Cold immersion tubs must be available for practices for the benefit of any player showing early signs of heat illness.

Please refer to BY-LAW 2.67- the Practice Policy for Heat and Humidity for more details:
http://www.ghsa.net/sites/default/files/documents/sports-medicine/HeatPolicy2013.pdf

It is recommended that all guidelines be followed in such a way that the best interests of our students be made our number one priority. It is also recommended that coaches constantly teach our students about proper hydration throughout each day. It is important that student-athletes be allowed to carry water with them during the day and hydrate themselves, on days of practices and games, while the weather has the possibility of reaching critical levels in relation to the heat and humidity.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

_____ _____

Student Athlete Signature ***Date***

_____ _____

Parent/Guardian Signature ***Date***

BETHESDA ACADEMY

Memorial Sports Medicine Experience Excellence.

School Year 2017-2018

Memorial Sports Medicine
CONCUSSION AWARENESS INFORMATION AND GUIDELINES

The purpose for this document is to provide crucial information for student-athletes and parents/legal guardians. This form must be signed by both the athlete and parent/legal guardian prior to tryouts, workouts or other forms of participation.

Concussion Awareness Information:

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short term or long-term). A concussion is a brain injury that results in temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

COMMON SIGNS OF A CONCUSSION:

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

Please refer to BY-LAW 2.68- Concussion policy for more details:
http://www.ghsa.net/sites/default/files/documents/sports-medicine/2013GHSAConcussion_Form.pdf

Student-Athlete Concussion/Head Injury Guidelines:

I affirm that:

- It is my responsibility as a student athlete or as the parent/legal guardian of a student athlete to report all injuries and illnesses to my Athletic Trainer or Memorial Sports Medicine representative.
- I have fully disclosed, in writing, all prior head injury related events and medical conditions and will disclose any future conditions to my Athletic Trainer or Memorial Sports Medicine representative.
- I understand the importance of and will immediately report any and all signs and symptoms of a head injury, including concussion, to the Memorial Sports Medicine representative or my Head Coach.
- I understand there is the possibility that participation in any sport may result in a head injury and/or concussion.
- I will be provided with the Heads Up-Concussion Fact Sheet / NCAA Concussion Fact sheet for student-athletes.
- If there are questions or I wish to discuss any areas and issues that are not clear to me concerning head injuries, I have the contact information of a Memorial Sports Medicine Athletic Trainer.
- I acknowledge that no piece of equipment can prevent injury/illness/concussion. Specifically, helmets or soccer headbands may help to prevent catastrophic head injury but do not significantly reduce the risk of a head injury, including concussion. I understand that it is my responsibility to wear (or to ensure the student-athlete wears) any equipment issued to me (or the student-athlete) in the appropriate manner.
- I agree to read and abide by all warning labels on any equipment before use.
- I have read and reviewed the following statement released by the National Operating Committee on Standards for Athletic Equipment (NOCSAE)
    - **Helmet Warning Statement** *(For those student-athletes who will play football at any level):*
        - **"Keep your head up. Do not use this helmet to butt, ram, or spear an opposing player with any part of this helmet or faceguard. This is in violation of football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent. No helmet can prevent all head or neck injuries a player might receive while participating in football."**

BY SIGNING I AFFIRM THAT I HAVE READ THIS FORM AND I UNDERSTAND ALL THE FACTS PRESENTED IN IT.

_____ _____

Student Athlete Signature ***Date***

_____ _____

Parent/Guardian Signature ***Date***

2017-2018

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

2017-2018

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/_____ L 20/_____ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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HE0503 9-2681/0410

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

2017-2018

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

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