PARENT'S MEDICAL STATEMENT AND EMERGENCY INFORMATION

FATHER'S WORK PHONE:	( )	FATHER'S CELL PHONE or PAGER	( )
MOTHER'S WORK PHONE:	( )	MOTHER'S CELL PHONE or PAGER	( )
FAMILY DOCTOR:		DR. PHONE:	( )
EMERGENCY CONTACT NAME:		RELATIONSHIP:	
EMERGENCY CONTACT PHONE:	( )	CELL PHONE or PAGER:	( )

Brief Medical History:

Please answer the following questions regarding your son/daughter/ward:

1.	Has had injuries requiring medical attention.	Yes	No
2.	Has had an illness requiring hospitalization.	Yes	No
3.	Is under physician's care at this time.	Yes	No
4.	Has had coughing, wheezing, or trouble breathing during or after activity.	Yes	No
	Has had asthma.	Yes	No
	Has had seasonal allergies that require medical treatment.	Yes	No
5.	Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	Yes	No
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Yes	No
6.	Have you ever passed out during or after exercise?	Yes	No
	Have you ever been dizzy during or after exercise?	Yes	No
	Have you ever had chest pain during or after exercise?	Yes	No
	Do you get more tired quickly than your friends do during exercise?	Yes	No
	Have you ever had racing of your heart or skipped heartbeats?	Yes	No
	Have you ever been told that you have a heart murmur?	Yes	No
	Has any family member or relative died of heart problems or of sudden death before age 55?	Yes	No
	Have you had a severe viral infection (for example, myocarditis, or mononucleosis) within the last month?	Yes	No
	Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No

7.	Have you ever had a head injury or concussion?	Yes	No
	Have you ever been knocked out, become unconscious, or lost your memory?	Yes	No
	Have you ever had a seizure?	Yes	No
	Do you have frequent or severe headaches?	Yes	No
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes	No
	Have you ever had a stinger, burner, or pinched nerve?	Yes	No
8.	Have you ever become ill or felt light headed from exercising in the heat?	Yes	No
9.	Is hearing impaired, has glasses / contact lenses.	Yes	No
10.	Has fixed or removable appliances in mouth.	Yes	No
11.	Is there a reason for this individual to avoid participation on a certain sport?	Yes	No

Please explain if yes response:____

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12. Record the dates of your most recent immunizations (shots) for:

Tetanus ______________________ Measles ______________________

Hepatitis B ______________________ Chickenpox ______________________

In case of injury I hereby give consent for my son /daughter to have initial first aid administered by school personnel in charge and to be transported to a doctor or hospital for further treatment if necessary.

X

Parent/Guardian Signature   Date