

Fall Sport _____
Winter Sport _____
Spring Sport _____

Fremont Area Medical Center

Medical History & Consent Form

School

Name: _____ SS#: _____
Last First MI

Address: _____ Phone#: _____
Street

_____ Emerg#: _____
City ST Zip

Parent/Guardian: _____ Day Phone: _____

Age: _____ Birthdate: _____ Gender: M / F Grade: 9 / 10 / 11 / 12

Family Physician: _____
Name City Phone

Insurance Company: _____ Phone: _____

Name of Policy Holder: _____

Policy#: _____ Group#: _____

Emerg Contact: _____ Phone: _____ Relation: _____

The above information is needed in the event of a medical appointment or registration.

Personal History (please fill out this side of form before examination)

Circle either "Yes" or "No" for each of the following conditions which may have occurred in the past 3 years. If you answer "Yes," please clarify in the space provided (dates, specific body part(s), surgery, etc...).

- Yes / No Are you allergic to any medications? _____
- Yes / No Do you have any other allergies? _____
- Yes / No Do you have asthma: If yes, list medication: _____
- Yes / No Have you had any severe asthma attacks? (dates): _____
- Yes / No Are you currently taking any medications? (list): _____
- Yes / No Have you been "knocked out" unconscious? (dates): _____
- Yes / No Have you had any other head injuries? _____
- Yes / No Have you had any neck injuries? _____
- Yes / No Have you had any shoulder injuries? _____
- Yes / No Have you had any elbow, wrist or hand injuries? _____
- Yes / No Do you presently have back pain? (circle all that apply)
Seldom Occasionally Frequently With Exercise After Heavy Lifting
- Yes / No Are you currently receiving treatment for back problems? _____
- Yes / No Have you had any knee injuries? _____
- Yes / No Have you had any ankle or foot injuries? _____
- Yes / No Have you suffered any severe muscle strains? _____
- Yes / No Have you had any other injuries not listed above? _____
- Yes / No Have you been hospitalized? _____
- Yes / No Has any family member died of a sudden, unexpected heart attack? _____
- Yes / No Have you ever fainted or passed out during exercise? _____
- Yes / No Have you ever been advised not to participate in sports by a doctor? _____
- Yes / No Are you presently suffering from any illness or injury? _____

CONSENT TO RELEASE MEDICAL INFORMATION

I understand that this physical is for no other purpose than to clear me for athletic participation. I understand it is not a physical for illnesses which may develop in the future. I further agree that such illnesses will be taken to the student health service, our personal doctor, or the athletic trainer for referral and care.

I give authorization to the trainer to evaluate and treat injuries that occur during my child's athletic participation. This includes immediate first aid treatment, X-ray, physical exam, follow-up care and rehabilitation. I understand the team physician has the authority to eliminate my child from further participation because of an injury and/or because of undue risk to the school. No records will be released to any one other than the attending physician unless given my written approval. I also give authorization for the trainer and coaches to discuss the injury evaluation and the rehabilitation of the injury. By signing this form, I hereby release the information to the school of my child's attendance.

Parent Signature

Date

Athlete will not be able to participate in athletics until form is completed in its entirety and signed by the athlete's parents and a physician.

