MEDICAL HISTORY FOR JENISON ATHLETES

(PHYSICAL MUST BE DATED AFTER APRIL 15 TO BE VALID FOR THE NEXT SCHOOL YEAR)

*****THIS PORTION TO BE COMPLETED BY PARENT*****

NAME____ SPORT______________________ **V, JV, FR** GRADE_______
(LAST) (FIRST)

ADDRESS____ CITY____________________________ ZIP______________

DATE OF BIRTH _____________________ AGE ____________ HOME TELEPHONE ____________________________________

FATHER'S NAME _____________________________________ MOTHER'S NAME____________________________________

FATHER'S DAYTIME # ________ - ___________ - ___________ MOTHER"S DAYTIME # ________ - __________ - __________

FAMILY DOCTOR_____________________________________ DOCTOR TELEPHONE_________________________________

OUR CHILD IS COVERED FOR ATHLETICS UNDER INSURANCE WITH____
FAMILY INSURANCE COMPANY

I,___________________________________THE PARENT OF__________________________RECOGNIZE THAT AS A RESULT OF ATHLETIC PARTICIPATION, MEDICAL TREATMENT ON AN EMERGENCY BASIS MAY BE NECESSARY AND FURTHER RECOGNIZE THAT SCHOOL PERSONNEL MAY BE UNABLE TO CONTACT ME FOR MY CONSENT FOR EMERGENCY MEDICAL CARE. I DO HEREBY CONSENT IN ADVANCE TO SUCH EMERGENCY CARE, INCLUDING HOSPITAL CARE, AS MAY BE DEEMED NECESSARY UNDER THE CIRCUMSTANCE AND TO ASSUME THE EXPENSE OF SUCH CARE.

I UNDERSTAND THAT MY SON OR DAUGHTER WILL BE EXPECTED TO ADHERE FIRMLY TO ALL ESTABLISHED ATHLETIC POLICIES OF THE SCHOOL DISTRICT AND THE MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION.

PARENT'S SIGNATURE____DATE_____________________________

*****THIS PORTION TO BE COMPLETED BY STUDENT*****

HISTORY	YES	NO		HISTORY	YES	NO
HAVE YOU EVER HAD:				**DO YOU HAVE:**		
ASTHMA				BACKACHES		
DIABETES				BLACKOUTS		
DIPHTHERIA				BLURRED VISION		
FAINTING				CONVULSIONS		
HEART DISEASE				COUGH		
JAUNDICE				FAINTING		
KIDNEY DISEASE				FREQUENCY OF URINATION		
PNEUMONIA				FREQUENT SORE THROATS		
POLIO MYELITIS				HEADACHES		
RHEUMATIC FEVER				NOSEBLEEDS		
RHEUMATISM				PAINFUL JOINTS		
RUPTURE				POUNDING OF HEART		
SCARLET FEVER				SHORTNESS OF BREATH		
TUBERCULOSIS				STOMACH PAINS		

Any Known Allergies
(Please Explain)

____
____
____
____

I UNDERSTAND THAT I WILL BE EXPECTED TO ADHERE FIRMLY TO ALL ESTABLISHED ATHLETIC POLICIES OF THE SCHOOL DISTRICT AND THE MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION.

STUDENT'S SIGNATURE____DATE____________________

*****THIS PORTION TO BE COMPLETED BY PHYSICIAN****

SYSTEM	NORMAL	ABNORMAL		SYSTEM	NORMAL	ABNORMAL
URINALYSIS				THYROID		
VISION				CHEST		
BLOOD PRESSURE				LUNGS		
PULSE RATE				HEART		
EARS				ABDOMEN		
NOSE				HERNIA		
THROAT				GENITALIA		
TEETH CAVITIES				NEUROLOGIC		
ORTHOPEDIC				MUSCULAR		

Can the following be given
(Please circle)

Tylenol **YES** **NO**

Advil **YES** **NO**

COMMENTS/RECOMMENDATIONS:____
____

I CERTIFY THAT I HAVE EXAMINED THE ABOVE STUDENT AND RECOMMEND HER/HIM AS BEING ABLE TO COMPETE IN SUPERVISED ATHLETIC ACTIVITIES.

SIGNATURE OF EXAMINING PHYSICIAN_________________________________ DATE________________

(PLEASE RETURN TO THE H.S. ATHLETIC OFFICE)