Springfield Public Schools

ANNUAL MEDICAL HISTORY
ATHLETICS DEPARTMENT

Please fill in every blank.

Student Name _____ Sex: M F DOB _____

Grade _____ Sport Registering for: _____

Parent/Guardian Name _____

Address _____ Home Phone _____

Mother/Guardian Workplace _____ Work Phone _____

Father/Guardian Workplace _____ Work Phone _____

Health Insurance Co. _____

Group No. _____ Policy I.D. No. _____

Date of Last Physical _____ Family Physician _____ Phone _____

Emergency contact when a parent/guardian cannot be reached: Work Phone _____

Name _____ Home Phone _____

Have you had any illness, injury or surgery that restricted activity in the past 12 months? ❑ **Yes** ❑ **No**

If Yes, please describe _____

Have you had any illness lasting more than one week in the past 12 months? ❑ **Yes** ❑ **No**

If Yes, please describe _____

Have you been examined by a physician or hospitalized in the past 12 months? ❑ **Yes** ❑ **No**

If Yes, please describe _____

Are you currently under a physician's care? ❑ **Yes** ❑ **No**

If Yes, please describe _____

Have you had an MRI, CT, bone scan, or X-ray in the past 12 months? ❑ **Yes** ❑ **No**

If Yes, please describe _____

Are you currently taking any medication? ❑ **Yes** ❑ **No**

If Yes, please describe _____

Please check "Y" (yes) or "N" (no) for *all* of the following. **Explain any "Y" answers** in the space provided (or use back of sheet). Include the **current status** of the condition. Please list any allergies or current medications.

Have you ever experienced:

CONDITION	Y	N	If Yes, Date	Explanation (Please complete this for any YES answer.)
Concussions	❑	❑	_____	_____
Stingers	❑	❑	_____	_____
Sprains	❑	❑	_____	_____
Strains	❑	❑	_____	_____
Asthma	❑	❑	_____	_____
Mononucleosis	❑	❑	_____	_____
Glasses/contacts	❑	❑	_____	_____
Allergies (bees?)	❑	❑	_____	

Please list any medical conditions the staff should be aware of: _____

_____

_____

I give permission for my student to participate in ALL sports.
❑ **Yes** ❑ **No** **If No, explain:**

_____

_____

_____

I hereby give permission to the District 19 representative to approve hospitalization, secure treatment or medication for the above named student. In case of an emergency and I cannot be reached, I hereby give my permission to the physician selected by the representative to order injections, anesthesia, or surgery for the student named above. Any direction to the contrary will be specified on the back of this form.

Parent/Guardian Signature _____ Date _____

Canary - Office
Blue - Teacher
Buff - Coach

ATH10-0809