



**MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION, INC.  
MEDICAL HISTORY**

- To be completed by parent or guardian or 18-year-old.
- Must be signed in three places by parent or guardian or 18-year-old.

**A current year physical is one given on or after April 15 of the previous school year**

|                          |              |       |                            |       |                      |     |
|--------------------------|--------------|-------|----------------------------|-------|----------------------|-----|
| STUDENT'S NAME           | LAST         | FIRST | SEX                        | GRADE | DATE OF BIRTH<br>/ / | AGE |
| STUDENT'S ADDRESS        | STREET       |       | CITY                       |       | ZIP                  |     |
| FATHER'S/GUARDIAN'S NAME | WORK PHONE   |       | MOTHER'S / GUARDIAN'S NAME |       | WORK PHONE           |     |
| FAMILY DOCTOR            | OFFICE PHONE |       | HOME PHONE                 |       |                      |     |

**INSURANCE STATEMENT & MEDICAL HISTORY**

**Our son / daughter will comply with the specific insurance regulations of the school district**

Family Insurance Co.

Contract #

Signature of Parent or Guardian or 18-Year Old

| HISTORY            | YES | NO | HISTORY            | YES | NO | HISTORY               | YES | NO |
|--------------------|-----|----|--------------------|-----|----|-----------------------|-----|----|
| Have you ever had: |     |    | Have you ever had: |     |    | Do you now have:      |     |    |
| Fainting           |     |    | Kidney Disease     |     |    | Painful Joints        |     |    |
| Diphtheria         |     |    | Tuberculosis       |     |    | Backaches             |     |    |
| Scarlet Fever      |     |    | Jaundice           |     |    | Pounding of Heart     |     |    |
| Rheumatism         |     |    | Sickle-Cell Anemia |     |    | Shortness of Breath   |     |    |
| Rupture            |     |    |                    |     |    | Frequent Urination    |     |    |
| Rheumatic Fever    |     |    |                    |     |    | Cough                 |     |    |
| Poliomyelitis      |     |    | Do you now have:   |     |    | Nosebleeds            |     |    |
|                    |     |    | Blurred Vision     |     |    | Frequent Sore Throats |     |    |
| Pneumonia          |     |    | Headaches          |     |    | Stomach Pains         |     |    |
| Asthma             |     |    | Fainting           |     |    |                       |     |    |
| Diabetes           |     |    | Convulsions        |     |    |                       |     |    |
| Heart Disease      |     |    | Blackouts          |     |    |                       |     |    |

**PHYSICAL EXAMINATION**

**To be completed by the examining MD, DO, Physician's Assistant or Nurse Practitioner & returned directly to the patient. (Categories may be added or deleted; check appropriate column.)**

| SYSTEM           | NORMAL | ABNORMAL | SYSTEM                      | NORMAL | ABNORMAL |
|------------------|--------|----------|-----------------------------|--------|----------|
| Urinalysis       |        |          | Thyroid                     |        |          |
| Vision           |        |          | Chest                       |        |          |
| Blood Pressure   |        |          | Lungs                       |        |          |
| Pulse Rate       |        |          | Heart                       |        |          |
| Ears             |        |          | Abdomen                     |        |          |
| Nose             |        |          | Hernia                      |        |          |
| Throat           |        |          | Genitalia / Testicular Exam |        |          |
| Teeth - Cavities |        |          | Neurologic                  |        |          |
| Orthopedic       |        |          | Muscular                    |        |          |

**RECOMMENDATIONS:**

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below.

~~BASEBALL - BASKETBALL - BOWLING - COMPETITIVE CHEER - CROSS COUNTRY - FOOTBALL - GOLF -  
GYMNASTICS - ICE HOCKEY - LACROSSE - SKIING - SOCCER - SOFTBALL - SWIMMING - TENNIS - TRACK - VOLLEYBALL - WRESTLING~~

SIGNATURE OF EXAMINER : X

CIRCLE ONE:

MD DO PA NP

PRINTED NAME OF EXAMINER

**MEDICAL TREATMENT CONSENT  
To be completed by Parent or Guardian or 18-Year old**

I, \_\_\_\_\_, an 18-Year-old or the parent or guardian 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 then-existing circumstances and to assume the expenses of such care.

SIGNATURE OF PARENT OR GUARDIAN OR 18-YEAR-OLD

DATE

X



**LOY NORRIX HIGH SCHOOL  
STUDENT AND PARENT/GUARDIAN  
CONSENT FORM**

**PLEASE PRINT:**

|                                       |                       |              |                |
|---------------------------------------|-----------------------|--------------|----------------|
| <b>STUDENT'S COMPLETE LEGAL NAME:</b> | <b>LAST</b>           | <b>FIRST</b> | <b>MIDDLE</b>  |
| <b>STUDENT'S DATE OF BIRTH:</b>       | <b>PLACE OF BIRTH</b> |              |                |
| <b>CIRCLE GRADE</b>                   | <b>07</b>             | <b>08</b>    | <b>09</b>      |
|                                       | <b>10</b>             | <b>11</b>    | <b>12</b>      |
|                                       |                       |              | <b>SCHOOL:</b> |

**STUDENT PARTICIPATION**

This application to participate is voluntary on my part and the information submitted is truthful to the best of my knowledge. I have never received money or negotiable certificates for merchandise in any amount, nor any emblematic award or merchandise worth more than twenty-five dollars (\$25.00) for participating in athletic events, nor have I ever competed under an assumed name. After I have represented my school in any sport, I will not compete in any outside athletic contest in this sport until after my school season has been completed.

I understand that I am expected to adhere firmly to all established athletic policies of my school district and the Michigan High School Athletic Association, such as those previously mentioned above as examples but which do not present all the policies to which I am subject.

X \_\_\_\_\_  
**SIGNATURE OF STUDENT** **DATE**

**PARENT OR GUARDIAN OR 18-YEAR-OLD CONSENT**

I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics; and I understand the possibility that serious injury may result from participating in athletic activities. He/she has my permission to accompany the team as a member on its out-of-town trips.

I further 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.

X \_\_\_\_\_  
**SIGNATURE OF PARENT**

This form must be on file in the school office before practicing with any athletic team.

(Please print)

**EMERGENCY INFORMATION – To be completed by Parent or Guardian or 18-Year-Old**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

IN EMERGENCY CONTACT: 1) \_\_\_\_\_ Phone: \_\_\_\_\_

or 2) \_\_\_\_\_ Phone: \_\_\_\_\_

My Family Doctor Is: \_\_\_\_\_

Please detail any special medical information

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(allergies, known drug reactions, current prescribed medications)

