TIMBERLANE REGIONAL MIDDLE SCHOOL
ATHLETIC HEALTH FORM

NAME _____ GRADE _____
ADDRESS _____ DATE OF BIRTH _____
CHILD'S PHYSICIAN _____ PHYSICIAN'S PHONE _____
CHILD'S DENTIST _____ DENTIST'S PHONE_____
HEALTH INSURANCE CO. _____ POLICY # _____
****
IN CASE OF EMERGENCY, NOTIFY:
NAME _____ RELATION: _____
STREET _____
TOWN _____ STATE _____
HOME TEL. # _____ WORK TEL. # _____
PERSON TO CONTACT IF PARENT CANNOT BE REACHED:
NAME _____ RELATION _____
STREET _____
TOWN _____ STATE _____
HOME TEL. # _____ WORK TEL. # _____

**********PLEASE ANSWER THE FOLLOWING QUESTIONS**********

		Circle one	
1.	Have you ever been told not to participate in any sport?	Yes	No
2.	Have you ever been unconscious or lost memory from a head injury?	Yes	No
3.	Have you ever had a fracture or dislocation?	Yes	No
4.	Have you ever had an injury or sprain to knees or ankles?	Yes	No
5.	Are you currently under a physician's care for any problems?	Yes	No
6.	Do you take any medicine daily?	Yes	No
7.	Have you ever fainted or blacked out during hard exercise?	Yes	No
8.	Do you have allergies? (hay fever, hives, asthma, bee stings, medicines)	Yes	No
9.	Have you ever been admitted to a hospital?	Yes	No
10.	Do you have any worries or other questions about your health?	Yes	No
11.	Do you have the loss or serious impairment of any paired organs? (Example: kidneys, testicles, ovaries, eyes, ears)	Yes	No
12.	Do you wear glasses or contact lenses?	Yes	No

EXPLAIN ANY QUESTIONS ANSWERED "YES": (Use back to explain the problem)

I hereby agree that the above statements of medical history are accurate, and give my consent for this student to participate in the sport of

_____

Signature of Parent/Guardian _____ Date _____