ADDRESS    STREET   CITY   20		LACT	FIRST	BIRTH DATE	SEX	GRADE	
ARENT(S) NAME  ADDRESS (IF DIFFERENT THAN STUDENT)  WORK TELEPHONE NO. HOME TELEPHONE NO.  AMILY PHYSICIAN'S NAME, PHONE NUMBER  arefully complete the following questions before your physical exam. Explain "YES" answers below.  YES has this athlete ever had hospitalization, surgery, hipty, serious medical or psychological illness?  Is this athlete now under the care of a physician or taking any medication?  Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports by this student?  Does this athlete were allosses or contact lenses? Give date of last eye exam if "YES"  Has this athlete ever blaced out, bear knocked out, lost consciousness or been dizzy during or after physical activity? Has this athlete ever blaced out, bear knocked out, lost consciousness or been dizzy during or after physical activity? Has this athlete ever blaced out, bear knocked out, lost consciousness or been dizzy during or after physical activity? Has this athlete ever blaced and to, been knocked out, lost consciousness or been dizzy during or after physical activity? Has this athlete ever had racing of the heart, skipped heart beat or heart murmur?  Has this athlete ever had racing of the heart, skipped heart beat or heart murmur?  Does this athlete ever had racing of the heart, skipped heart beat or heart murmur?  Does this athlete use special protective/corrective equipment that first usually used?  (For example knee brace, ankel brace, loot orthotics, hearing aid, etc.)  Does this athlete use special protective/corrective equipment that first the sport?  Does this athlete lose weight regularly to meet weight requirements for the sport?  Does this athlete lose weight regularly to meet weight requirements for the sport?  Does this athlete lose weight regularly to meet weight requirements for the sport or weight protective or the sport of the sport and the sport of the sport heart or the protective of the sport or the sp	ADDRESS			PLA	CE OF BIRTH		
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Has this athlete ever had a seizure?	Has this athlete ever	had racing of the	heart, skipped heart bea	at or heart murmur?			
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SURANCE COMPANY:   YES   NO   If yes, the Child is covered by: POLICY NO.   EFFECTIVE DATE:    HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAM    FUDENT'S HEIGHT   WEIGHT   BP   PULSE   URINALYSIS   ALBUMIN   SUGAR   MICRO (IF ABOVE TEST // BLOOD COUNT (FOR FEMALES)   HGB. OR HCT.   HGB. HGB. OR HCT.   HGB. HGB. HGB. HGB. HGB. HGB. HGB. HGB.	amages and losses susta articipants Signature _	ained by me and ar	officers, agents, servants ising out of, connected wi	ase and discharge and agree to indemr and employees from any and all claim th, or in any way associated with activ	nify and hold harmless is resulting from injuri ities of the program. Date	on in this C s and defen es, includir	YO progr d the You ng loss of
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## **EMERGENCY MEDICAL AUTHORIZATION**

		Student Name
		Address
		Telephone
Purpose:		lians to authorize the provision of emergency treatment r injured while under school authority, when parents or d.
	_	MUST BE COMPLETED O GRANT CONSENT
In the event i	reasonable attempts to contact m	ne at(phone number) arent or guardian) at
(phone numl treatment of	oer) have been unsuccessful, I h deemed necessary by Dr	nereby give my consent or: (1) the administration of any(preferred
designated p	oreferred practitioner is not avail of the child toaccessible.	(preferred dentist), or, in the event the lable, by another licensed physician or dentist; and (2) (preferred hospital) or any hospital
physicians of performance Facts conce	or dentists, concurring in the need of such surgery.  Tring the child's medical history	gery unless the medical opinions of two other licensed lecessity for such surgery, are obtained prior to the including allergies, medications being taken, and any hould be alerted:
 Date		Signature of Parent or Guardian
		Address
		RT II IFYOU COMPLETED PART I FUSAL TO CONSENT
	ny consent for emergency medical to eatment, I wish the school authorities	reatment of my child, in the event of illness or injury requiring es to take no action or to:
Date		Signature of Parent or Guardian
		A.11

First

MU-SSM-12 Rev. 1985

Address