

WINNACUNNET HIGH SCHOOL HEALTH FORM
For Participation in Interscholastic Athletics

Student's name _____ Date of Birth _____

Address _____

City/Town _____ State _____ Zip Code _____

In case of emergency notify:

Name _____ Relationship: ____ Parent ____ Guardian

Address _____

Home Phone _____ Other Phone _____

NOTE TO PARENTS: Please fill out this page carefully, have your son/daughter take it to the examining physician and follow the doctor's advice about limitations.

HEALTH HISTORY

Has had: (check if "yes" and describe)

_____ Head or brain injury	_____ Heart condition or heart disease	_____ Hernia
_____ Unconsciousness	_____ Diabetes	_____ Kidney injuries
_____ Sprains of any joints	_____ Broken bones	_____ Other
_____ Asthma/Allergies	_____ Serious eye trouble	

Describe: _____

DO YOU TAKE ANY MEDICATIONS REGULARLY OR ON AN AS NEEDED BASIS?

Have ever been: (check if "yes" and explain)

_____ Treated by a doctor _____ Admitted to a hospital _____ Operated on

Explain: _____

DO YOU NEED TO WEAR GLASSES, CONTACTS, BRACES OR ANY OTHER FORM OF PROTECTION FOR SPORTS? _____

PARENTAL OR GUARDIAN PERMISSION

I hereby give my consent for the above student to engage in approved high school athletics and also agree that the above statements of medical history are accurate. I also give permission to give tetanus immunizations when necessary.

DATE

SIGNATURE OF PARENT/GUARDIAN

PHYSICIAN MUST COMPLETE THE OTHER SIDE OF THIS FORM.

PHYSICAL EXAMINATION FORM FOR ATHLETIC PARTICIPATION

To be completed by the examining physician:

Name of Student _____ Grade _____

Height _____ Weight _____ Age _____ DOB _____

Body development: (Circle number) 10 9 8 7 6 5 4 3 2 1
(Heavy) (Medium) (Slender)

Blood Pressure: _____

Sports participating in: _____

EXAMINATION:

	Satisfactory	Unsatisfactory	Explain if unsatisfactory
Teeth/Gums	_____	_____	
Extremities	_____	_____	
Heart/Lungs	_____	_____	
Hernia	_____	_____	
Neurological/Muscular	_____	_____	
Orthopedic/Spine	_____	_____	
Glands	_____	_____	
Skin/Scalp	_____	_____	
Abdomen	_____	_____	
Nose/Throat	_____	_____	
Eyes	_____	_____	
Ears	_____	_____	
Tanner Stage	_____	_____	

Special Concerns: _____

Recommendations for athletic participation: _____

Date examined _____ Today's date _____

Date of last tetanus immunization _____

By: _____
(Signature of physician licensed to practice medicine)

THIS FORM MUST BE DATED JUNE 1, 2008 OR AFTER.
THIS MEDICAL RECORD WILL BE FILED IN THE ATHLETIC OFFICE.