SPORTS PHYSICAL FORM

Please read each section and fill out completely:

PARENTAL CONSENT

I hereby give consent for _____to participate in interscholastic athletics at Wingate High School.

AUTHORIZATION FOR MEDICAL SERVICES

In the event of injury/illness we request that we be contacted within a reasonable amount of time if my child needs medical attention. In the event we cannot be reached. We designate the Athletic Director, Head Coach, Athletic Trainer or his/her designee to act in our behalf to authorize the necessary medical services required in an injury/illness sustained while participating in school athletics. In the event we cannot be reached and the situation calls for medical personnel acting in the best interest of our child, we hereby give consent. We assume financial responsibility for hospitalization, medical costs and/or surgery as needed.

Family Physician: _____ Phone: _____

Address: _____

Family Dentist: _____ Phone: _____

Address: _____

Hospital Preference: _____

Parent/Guardian Telephone# Home: _____ Work: _____

Cell#: _____ Emergency Contact#: _____

INTERSCHOLASTIC PHYSICAL EXAMINATION FORM

Wingate High School strives to provide the best possible athletic programs for students. Athletic participation needs to be a valuable educational experience at all levels. Please read the following carefully and discuss its contents with your child, and bring it to your family physician for approval. This form is to be fully completed and filed with the school before your child allowed to practice and/or compete. We require a physical examination to ensure your child is physically able to participate in athletics and in the event a medical emergency occurs.

1. Parental Consent: We want you ensure your child is participating in sports with your consent. It is necessary for you and your child to read and understand the reason for the examination and the expectations of sports participation.

2. Eligibility: Rules governing eligibility are based on the Wingate High School administration and the New Mexico Activities Association (NMAA) guidelines.

Medication Notification

For my personal safety and protection, I, the student-athlete, will inform the athletic director, athletic trainer, and/or medical personnel if I am taking any medication, using any ointment, liniment, balm or have a metal implant in my body before receiving treatment.

_____ _____

Parent/Guardian Signature Athlete Signature

_____ _____

Address EMERGENCY PHONE NUMBER

THIS FORM MUST NE IN THE POSSESSION OF THE COACH AT ALL ATHLETIC EVENTS

Medical Examination (Physician Only)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Eyes Uncorrected R 20/ _____ E 20/ _____ Corrected R 20/ _____ L 20/ _____

	Normal	Abnormal	Remarks
EEBT	_____	_____	_____
Respiratory	_____	_____	_____
Cardiovascular	_____	_____	_____
Abdomen	_____	_____	_____
Hernia	_____	_____	_____
Genitalia	_____	_____	_____
Musculoskeletal	_____	_____	_____
Deformities	_____	_____	_____
Surgical Scars	_____	_____	_____
Skin	_____	_____	_____
Urinalysis (sugar)	_____	_____	_____

I certify that I have reviewed the above history and examined the individual and find him/her physically able to compete in interscholastic athletics.

Attending Physician: _____

Date of Examination: _____ Physician Address: _____

Physician Phone Number: _____ Physician Signature: _____

Comments:

_____

_____

_____

SPORTS PHYSCIAL HEALTH HISTORY

Name: _____ Age: _____ Date: _____

Birth Date: _____ Tribe: _____

CIRCLE ONE

1. Have you ever had heart trouble? YES NO
2. Have you ever had seizures or convulsions? YES NO
3. Have you ever had high blood pressure? YES NO
4. Have you ever had kidney disease? YES NO
5. Have you ever had liver disease? (jaundice or hepatitis) YES NO
6. Have you ever had tuberculosis (TB)? YES NO
7. Have you ever had a positive skin test for TB? YES NO
8. Have you ever had diabetes? YES NO
9. Do you have arthritis or sore joints? YES NO
10. Have you ever had rheumatic fever? (heart murmur/infection)? YES NO
11. Have you ever had Venereal Disease? YES NO
12. Have you ever been hospitalized? YES NO

    For What: _____
13. Are you anemic? YES NO
14. Are you now under the care of a physician? YES NO
15. Are you under any medication? YES NO
16. Are you allergic to anything, like drugs or food? YES NO
17. Have any drugs ever made you sick? What? _____ YES NO
18. Do you have trouble stopping the bleeding when you cut yourself? YES NO
19. Have you ever had a tooth extracted? YES NO
20. Have you ever had any trouble while receiving dental treatment? YES NO
21. WOMEN: When was your last menstrual period? Date: _____
22. Are you pregnant? YES NO
23. GIMC CHART#: _____ Soc Sec #: _____
24. REMARKS: _____

_____ _____

Signature (if minor, Parent/Guardian) Address

Phone#: _____ dd