Athletic Permission & Medical Form
Bishop Stang High School
(Complete Both Sides: Please Print)

DATE _____

Student-Athlete Information

_____ FR SO JR SR
SPORT(S) CLASS YEAR

_____ M F
FIRST NAME LAST NAME GENDER

_____
MAILING ADDRESS CITY STATE ZIP

_____
TELEPHONE DATE OF BIRTH

Medical History

Yes	No	
O	O	Are you currently being treated for any health condition? If, yes explain: _____
O	O	Do you have any chronic or recurrent type of injury that needs protection or support? If yes, explain: _____
O	O	Have you had any joint injuries or fractures in the last two years? If yes, list injury and dates: _____
O	O	Have you had surgery for an illness or injury within the last two years? If yes, describe: _____
O	O	Do you have any blood disorders? If yes, explain: _____
O	O	Do you have any eating disorders? If yes, explain: _____
O	O	Have you ever been treated for heat exhaustion or dehydration? If yes, list for what and dates: _____
O	O	Have you had a major illness in the past twelve months? i.e, mono, pneumonia, meningitis, etc. If yes, explain:_____
O	O	Have you ever passed out during or after exercise? When: _____
O	O	Have you ever been dizzy during or after exercise? When:_____
O	O	Have you ever experienced chest pain during or after exercise? When:_____
O	O	Have you ever been told you have a heart murmur? When: _____
O	O	Has any relative died of heart problems or suffered sudden death before the age of 50? If yes, who: _____
O	O	Are you missing any paired organs? i.e., eyes, lungs, kidneys, testicles, etc. If yes, list: _____
O	O	Has a physician ever denied or restricted your participation in sports for any health reasons? If yes, explain:_____
O	O	What was the date of your last tetanus shot? _____

(Complete Both Sides: Please Print)

Authorization For Medical Treatment

STUDENT FIRST NAME | STUDENT LAST NAME

PARENT/GUARDIAN FIRST NAME | PARENT/GUARDIAN LAST NAME

MAILING ADDRESS | CITY | STATE | ZIP

HOME TELEPHONE | WORK TELEPHONE | CELL PHONE

ALTERNATE EMERGENCY CONTACT PERSON FIRST NAME | ALTERNATE EMERGENCY CONTACT PERSON LAST NAME | RELATIONSHIP TO STUDENT/ATHLETE

ALTERNATE EMERGENCY CONTACT INFO: HOME TELEPHONE | WORK TELEPHONE | CELL PHONE

PHYSICIAN'S NAME | PHYSICIAN'S TELEPHONE

Please Answer the Following:

Please check if the student-athlete has any of the following:

O DIABETES O EPILEPSY O HEART CONDITION O ASTHMA O HIGH BLOOD PRESSURE OTHER _____

Does the student-athlete wear contact lenses to participate? O Yes O No

Please list all the medications including inhalers and directions for use:

Please list all allergies, including medications, food, and insects:

Please list any other pertinent medical information:

Please Provide Insurance Information:

POLICY NAME | POLICY NUMBER | SUBSCRIBER'S NAME

Parent/Guardian Permission

I give my child permission to participate in athletics at Bishop Stang and use the transportation provided by the school.

I give my permission for the evaluation/treatment of my child by the certified athletic trainer and any duly licensed physician and/or hospital facility in the event of illness or injury.

I authorize transportation in an ambulance of my child, if necessary.

I verify that the responses on the medical history questionnaire & authorization for medical treatment are true to the best of my knowledge.

PARENT GURADIAN SIGNATURE | DATE