TOUTLE LAKE YOUTH FOOTBALL
ATHLETE HISTORY AND PHYSICAL CARD

Student: _____ Grade Next School Year: _____

Date of Birth: _____ Age: _____ Male Female
(Circle one)

Home Phone: _____ Mother Cell: _____ Father Cell: _____

Physical Address: _____ _____ _____
House number street name City Zip

This application to compete in interscholastic athletics for the Toutle Lake School District is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules or regulations of the school or state associations.

_____
Student Signature

RISK AWARENESS

Participation in any athletic activity will likely involve injury of some type to either yourself or a fellow student athlete. Such injury can include direct physical and possibly crippling injury to one's body or the possibility of emotional injury experienced as a result of witnessing or actually inflicting injury to another. The severity of such injury can range from minor cuts, scrapes or muscle strains to catastrophic injury, such as complete paralysis or even death. Such injury can impair one's general physical and mental health and hinder one's future ability to earn a living, engage in other business, social and recreational activities, and generally to enjoy life.

MEDICAL INFORMATION

Do you give permission for this student to take a physical examination from a school-selected physician?
Yes _____ No_____
Do you give your permission for a doctor to administer treatment to your child and to inform school officials the nature of the injury? Yes_____ No_____
It is the parent's responsibility to notify the school any time a medical problem occurs that would affect the health of the student as he/she participates in athletics.

ATHLETIC INSURANCE INFORMATION

All interscholastic athletes must be covered by medical insurance provided by the parent or guardian. The above named student will be covered in one of the following ways (please check one):

_____ Complete coverage with personal insurance / Name of insurance company:_____

_____ School insurance / to be purchased through District Office. (Forms available from High School and District offices in August)

_____ _____ _____
Name of Physician **Address** **Phone**

PARENT OR GUARDIAN

I have read and completed all the sections of this form, (front & back) and all statements are true to the best of my knowledge. I hereby give consent for the above named student to engage in school and state association approved athletic activities as a representative of his/her school. I also give my consent for this student to accompany the team when it travels to other schools.

GENERAL

_____ _____
Parent or Guardian Signature **Date**

OFFICE USE ONLY: HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____
PULSE _____ VISUAL ACUITY: LEFT 20 /_____ RIGHT 20/ _____

1.	Do you have any allergies (medicine, bees or other stinging insects)?	Yes	No
2.	Have you ever been hospitalized?	Yes	No
3.	Have you ever had surgery?	Yes	No
4.	Are you presently taking any medication or pills?	Yes	No
5.	Do you have any skin problems (itching, rashes, acne)?	Yes	No
6.	Have you had any other medical problems (asthma, diabetes, etc.)?	Yes	No
7.	Have you had a medical problem or injury since your last evaluation?	Yes	No

*Please explain **YES** answers*

HEART LUNG

1.	Have you ever passed out during or after exercise?	Yes	No
2.	Have you ever been dizzy during or after exercise?	Yes	No
3.	Have you ever had chest pain during or after exercise?	Yes	No
4.	Do you tire more quickly than your friends during exercise?	Yes	No
5.	Have you ever had high blood pressure?	Yes	No
6.	Have you ever had or been told you have a heart murmur of rheumatic fever?	Yes	No
7.	Have you ever had racing of your heart or skipped heartbeats?	Yes	No
8.	Has anyone in your family died of heart problems or sudden death before age 50?	Yes	No
9.	Have you ever had heat or muscle cramps?	Yes	No
10.	Have you ever been dizzy or passed out in the heat?	Yes	No
11.	Do you have trouble breathing or do you cough during or after activity?	Yes	No

*Please explain **YES** answers.*

EAR, EYE, NOSE, and THROAT

1.	Have you ever had any problems with your eyes or vision?	Yes	No
2.	Do you wear glasses, contacts, or protective eyewear?	Yes	No
3.	Do have a known hearing loss?	Yes	No

*Please explain **YES** answers.*

MUSCULO-SKELETAL/NEUROLOGICAL

1.	Have you ever had a head injury?	Yes	No
2.	Have you ever been knocked out or unconscious?	Yes	No
3.	Have you ever had a seizure?	Yes	No
4.	Have you ever sprained/strained, dislocated, fracture, broken, or had repeated swelling or other injuries of any bones or joints?	Yes	No

Head _____ Shoulder_____ Neck_____ Chest_____
Elbow_____ Forearm_____ Shin/calf_____ Back_____
Hip_____ Hand _____ Foot_____ Knee_____ Ankle_____

*Please explain **YES** answers.*

ABDOMEN

1.	Have you ever had abdominal surgery or problems?	Yes	No
2.	Have you had hepatitis or mononucleosis?	Yes	No

*Please explain **YES** answers.*

QUESTION FOR FEMALES ONLY

1.	Do you or have you had menstrual problems?	Yes	No

I certify that I have, on this date examined the above named student and recommended him/her as being physically able to participate in supervised activities except as indicated
Limitations and restrictions: _____

_____ _____
Examining Physician Date