

# 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 you 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