PARTICIPANT'S MEDICAL TREATMENT CONSENT FORM

Athlete's Information

Last Name_____________________________ First Name____________________________ Middle Name__________________

Date of Birth__________________ Home Phone___________________________ Cell Phone ____________________________

Medical Information

Family Physician/Clinic ______________________________________ Telephone Number____________________________

Family Medical/Hospital Insurance Carrier________________________ Preferred Hospital____________________________

Policy #:_______________________ Group #:_____________________ Immunizations up to date (Circle One) Yes No

Date of Last Tetanus Shot:______________ List All Current Medications:____

Please Check All That Apply:

Since your child's last health exam, has he or she had:	**Allergies:**	**Chronic or Recurring Illness:**	**Other Health Conditions:**
o Serious injury requiring medical treatment? o Treatment in a hospital or Emergency room? o Exposure to a contagious Disease? o Illness lasting more than 5 Days? o Surgical operation or Fracture? o Physical activity Restrictions?	o Animals o Insect stings o Food o Hay Fever o Medicine/Drugs o Plants o Pollen o Other (Specify) ______________________ ______________________	o Asthma o Bleeding/Clotting disorders o Diabetes o Ear Infection o Heart defect/disease o Hypertension o Musculoskeletal disorders o Seizures o Anemia o Other (Specify) ______________________ ______________________	o Constipation o Emotional disturbances o Fainting o Hearing impairment o Vision Impairment __Glasses __Contacts o Motion sickness o Nosebleeds o Special dietary regimen o Obesity o Other (specify) ______________________

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.____

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By signing below, I am verifying that the information I provided in this health history is accurate and complete. Also, I understand that all medications my child is to take during track meets must be administered by an adult in charge. Therefore, I am responsible for providing medications, written instructions and permission to that adult.

Signature of Parent/Guardian____ **Date**__________________________