

**ROCKY HILL HIGH SCHOOL ATHLETIC DEPARTMENT
REGISTRATION/MEDICAL CONSENT/PHYSICIANS STATEMENT FORM**

STUDENT: _____ **Grade:** _____
LAST NAME FIRST M.I. M/F D.O.B.

ADDRESS: _____

_____ **HOME TELEPHONE:** _____ **CELL:** _____

PARENT/GUARDIAN: _____ **WORK PHONE:** _____

(To be completed by Student and Parent/Guardian)

- | | | |
|---|-----------|----------|
| 1. Do you have any allergies (drug, food, insect stings, etc)? | Yes _____ | No _____ |
| 2. Do you require an EpiPen? | Yes _____ | No _____ |
| 3. Are you currently taking drugs or medications (include steroids, inhalers, and supplements)? | Yes _____ | No _____ |
| 4. Are you being treated for any condition by a physician or other health professional? | Yes _____ | No _____ |
| 5. Have you ever been advised by a doctor not to participate in sports? | Yes _____ | No _____ |
| 6. Do you have any chronic conditions or diseases (i.e. asthma, diabetes, etc) | Yes _____ | No _____ |
| 7. Have you ever suffered a concussion or head injury? | Yes _____ | No _____ |

If you answered YES to any of the above, please explain below:

8. Have you ever been hospitalized for medical or surgical reasons? Yes _____ No _____

If yes, please provide the following information:

Reason: _____ Year _____

9. Please list below any injury that you have had which prevented you from participating in regular life activities for one week or More.

Injured area: _____ Year _____ Type of Injury _____

I/we hereby state that we have reviewed this medical history and certify that the information supplied above is correct. I/we give permission for the above named student to participate in all sports including contact sports.

(student signature) (date) (parent/guardian signature) (date)

(To be completed by Physician)

Please check if normal findings: Respiratory _____ Orthopedic _____ HEENT _____
 Cardiovascular (arrhythmia, murmur) _____ Neurological _____

Please indicate below any known conditions, illnesses, allergies, or prior injuries, which could affect or limit participation in sports and/or medical treatment:

I hereby certify that _____ is in good health and physically able to participate in all sports including contact sports. This certificate is valid for the school year 2008-2009 unless voided by any serious injury or illness.

 (Physician's Name) PLEASE PRINT (Physician's Signature) (Date)

THIS COMPLETED FORM IS TO BE PRESENTED TO THE DIRECTOR OF ATHLETICS DURING THE PRESEASON REGISTRATION PERIOD.