Crusader Sports Health Form

Date: ____________________
Student Name: ___________________________ Date of Birth: _________________

Name of Physician: ______________________________Phone:_________________
Name of Dentist: : ________________________________Phone:_________________
Family Medical Insurance: ____
Policy/Group #: ____
Name of Insured: ____

Emergency Contact:
Name: ____
Address: ____
Phone____
Relationship to Athlete: ____

Date of last physical:______________
Any problems noted? ____
____
Are immunizations current? ____

Please list any medications you are currently taking:
____

Please list any other information that you would like the coach to be aware of:
____

Please answer the following questions:

1. Any injury requiring medical attention in the last 12 months** YES NO
   Explain: ____
   **A doctor's release may be required for athlete to participate

2. Any serious illness lasting more than 5 days? YES NO
   Explain: ____

3. Do you wear: glasses ________ contacts ________ braces ____________?

4. Any known allergies? YES NO
   Explain: ____

5. Do you have a chronic condition, disease or are you currently under a physician's care? YES NO

Explain: ____

We clearly understand that the above questions are to assist in determining whether or not this student is in the proper condition to participate in interscholastic sports. To the best of our knowledge these answers are correct as of the date this form is signed. We also understand that the above information will be kept confidential and disclosed to the coach on a need to know basis.

Signature of Parent/Guardian: ____________________________________ Date: _______

Signature of Student: ____ Date: _______

A "Yes" answer to any of these questions does NOT mean disqualification from eligibility, although we may ask for a sports physical or medical clearance to be completed by your physician.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the Crusaders to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child/me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Crusaders in charge to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied or scanned for use off-site.

Signature of parent/guardian:____

Signature of participant:____

Approved __________________ Refused ___________________

Reason for refusal: ____

AD Signature: ____ Date: _____________