Burbank Unified School District

Athletic Emergency/Medical Information & Participation Form

PLEASE USE A BLACK OR BLUE BALL POINT PEN

Name (Student Athlete):_____ Address: _____

City:_____ State:_____ Zip Code:_____ Home Phone: (_____)_____ Today's Date: _____

Grade:_____ Age:_____ Date of Birth:_____ Sex:_____ ID Number _____

Father's or Guardian Name:_____ Employer:_____ Phone: (_____) _____

Mother's or Guardian Name:_____ Employer:_____ Phone: (_____) _____

Emergency Phone: (_____)_____ Family Physician:_____ Phone: (_____) _____

Health Insurance Provider: _____ Policy #_____ Does the insurance cover football? ☐Y ☐N

School attended previous semester: _____ Place of Birth: _____

List all schools attended in the last 12 months: 1)_____ 2)_____ 3) _____

CHECK ALL SPORTS IN WHICH THIS STUDENT WILL PARTICIPATE IN:

FALL		WINTER	SPRING		YEARLONG	
❑ Football	❑ Girls Golf	❑ Soccer	❑ Softball	❑ Boys Golf	❑ Pep Squad	❑ Drama
❑ Cross Country	❑ Girls Volleyball	❑ Basketball	❑ Baseball	❑ Swim	❑ Dance Team	❑ IMA
❑ Girls Tennis	❑ Marching Band	❑ Girls Water Polo	❑ Boys Tennis	❑ Track	❑ VMA	
❑ Boys Water Polo			❑ Boys Volleyball	❑ Powderpuff		

Medical History Questionnaire - ***This section must be completed by a parent or guardian.*** Name of Person Filling Out Form: _____

	Yes	No		Yes	No
1. Are you currently under a doctor's care for any reason?			15. Have you ever been dizzy or passed out due to the heat?		
2. Have you ever been hospitalized?			16. Do you have trouble breathing after exercise?		
3. Have you had surgery within the last 3 months?			17. Have you had any problems with your eyes or vision?		
4. Are you currently taking any medications or pills?			18. Do you wear glasses or contacts or protective eyewear?		
5. Do you have any known allergies (medicines, bee stings, etc.)?			19. Do you use any special equipment (splints, neck rolls, mouth guards, etc.)?		
6. Have you ever been dizzy or fainted during or after exercise?			20. Has anyone in your family died of heart problems or sudden death before the age of 50?		
7. Have you ever had chest pains during or after exercise?			21. Do you have only one working organ of usually paired organs? (eyes, kidneys, etc.)		
8. Have you ever had high blood pressure?			22. Have you ever sprained, broken, dislocated, or had repeated swelling or pain of any bones or joints?		
9. Have you ever been told you have a heart murmur?			23. Have you ever had a stinger, burner or pinched nerve?		
10. Have you ever had a racing heart or skipped heartbeats?			24. Have you had any medical problems or injuries? (asthma, mono, diabetes, etc.)		
11. Have you ever had a head injury?			25. Have you had any medical problems or injuries since your last physical?		
12. Have you ever been knocked unconscious?			26. Were there any special instructions or precautions given by the doctor?		
13. Have you ever had a seizure?			27. When was the date of your last tetanus shot?		
14. Are any of the following currently bothering you? ❑ Hand ❑ Wrist ❑ Elbow ❑ Forearm ❑ Hip ❑ Thigh ❑ Knee ❑ Ankle ❑ Shin/Calf ❑ Foot					

Explain all "Yes" answers by question number. Indicate dates for each item and include any special instructions: _____

I/we hereby state, to the best of my/our knowledge, the answers to the questions for the medical history questionnaire above is true. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for medical care of this individual. **I understand that this is only a pre-season screening and should in no way replace a complete physical by your own doctor as recommended. I/we verify that I/we have read and understand all material presented and all information I/we have provided is correct and I/we give permission for my/our child or ward to receive a physical exam and to participate in athletics.**

In the event ***reasonable attempts*** to contact the parent/guardian at the above phone numbers meets with no success, ***full authorization*** is given for the administration of any treatment deemed necessary by a medical practitioner, and the transfer of son/daughter or ward to any medical practitioner, and the transfer of my/our son/daughter or ward to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the school authorities and aforesaid agent(s) to give reasonable care. Facts are provided concerning the student athlete's medical history which a medical practitioner should know.

Parent/Guardian Signature:_____ **Date:**_____

Physician's Report (to be filled out by Physician)

Date of last physical exam:_____
Blood Pressure:_____
Height:_____ **Weight:**_____ **Pulse Rate:**_____

Physician's Stamp Here

LIST ANY RESTRICTIONS THE ABOVE STUDENT MAY HAVE:_____

I hereby certify that the above named individual was examined by me on the above date and found physically fit to engage in interscholastic athletics.

Physician Signature:_____ **Date:**_____

Student Label Here