

Central Kitsap School District Medical History and Waiver - Emergency Reference

Name: _____ (M/F) DOB: _____ Sport: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip) (Telephone)

Parent/Guardian Telephone (H/W) _____ Cellular/Pager: _____
 Parent/Guardian Telephone (H/W) _____ Cellular/Pager: _____
 Emergency contact #1: _____ Telephone (H/W): _____
 Emergency contact #2: _____ Telephone (H/W): _____
 Athlete's physician: _____ Telephone: _____
 Insurance carrier: _____ Telephone: _____
 Policy holder's name: _____ Policy number: _____

Please circle "Yes" or "No". Please provide additional details to any questions answered "Yes" in 1-11 below.

1. Yes/No Has any medical condition, which may affect athletic participation? _____
What? _____
2. Yes/No Has had injuries/illness lasting more than one week in the last year? _____
What? _____
3. Yes/No Has any food, pollen or drug allergy? _____ Which? _____
Describe the severity of reaction: _____
4. Yes/No Is presently taking medication of any kind? _____
What? _____ Is self-medicated? _____
5. Yes/No Is presently under a physician's care? _____ Why? _____
Physician's name: _____ Released to participate date: _____

6. Yes/ No Has high blood pressure? _____ Heart disease? _____ Organ abnormalities? _____
7. Yes/No Has a history of a concussion, seizure, epilepsy or headaches? _____
8. Yes/No Has been medically diagnosed with heat exhaustion/stroke? _____
9. Yes/No Has been professionally diagnosed with exercise induced asthma? _____
Describe the severity of reaction: _____
10. Yes/No Has been hospitalized for injury or illness? _____
What? _____ When? _____
11. Yes/No Has had any injury or illness requiring medical attention in the past three years? _____
What? _____ When? _____
12. Yes/No Has been immunized for Tetanus? _____ When? _____

Please provide additional details in this space to any questions answered "Yes" in 1-11.

The information provided above is accurate. In the event of injury or illness, the athlete stated above may be transported to a medical facility for care. As the legal authority of the above person, I hereby give my permission to medical personnel to provide treatment as needed. I understand and agree that medical information may be shared with other healthcare professionals.

Parent/Guardian Signature: _____ Date: _____