SEGERSTROM HIGH SCHOOL 2018-19

ATHLETICS MEDICAL SCREENING FORM

Last Name:_____ First: _____ DOB:_____
ID #_____ Gender (circle one) Male / Female

HEALTH HISTORY TO BE COMLETED BY STUDENT-ATHLETE AND PARENT PRIOR TO MEDICAL SCREENING EVALUATION.		
Head injury/concussion	❒ Yes	❒ No
Bone/join disorders (broken bones, dislocations, disease, surgery, trick joints, arthritis)	❒ Yes	❒ No
Anemia, leukemia, bleeding disorders	❒ Yes	❒ No
Kidney/bladder problems	❒ Yes	❒ No
Eye problems	❒ Yes	❒ No
Heart trouble, rheumatic fever	❒ Yes	❒ No
Tuberculosis, asthma, bronchitis	❒ Yes	❒ No
Ulcers, stomach trouble	❒ Yes	❒ No
Allergies	❒ Yes	❒ No
Dizzy spells, fainting or convulsions	❒ Yes	❒ No
Diabetes, hepatitis, jaundice	❒ Yes	❒ No
Hernia	❒ Yes	❒ No
Taking medication regularly	❒ Yes	❒ No

IF YES, PROVIDE DETAILS:

MEDICAL SCREENING EVALUATION MUST BE COMPLETED BY YOUR PHYSICIAN AND DATED AFTER JUNE 1ST OF THE CURRENT SCHOOL YEAR.	
❒ CLEARED FOR FULL PARTICIPATION	❒**NOT CLEARED FOR PARTIPATION: SPECIALIST CLEARANCE/FOLLOW UP REQUIRED**
MD RECOMMENATIONS OR RESTRICTIONS:	

BP	HR	HT	WT	EYE CHART: R L	GLASSES/CONTACTS	BRACES/TEETH
HEENT	HEART	LUNGS	ABDOMEN	HERNIA	BACK	EXTREMETIES

MD PHONE NUMBER ( )	MD PRINT NAME	MD STAMP
DATE	MD SIGNATURE	

PARENT CONSENT, ACKNOWLEDGEMENT, AND SIGNATURE

CONSENT: By signing below, I hereby give my permission for a screening evaluation.
ACKNOWLEDGEMENT: I hereby give my consent for [above named student], hereafter named student, to compete in athletics. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorized the medical agency to render treatment. I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital it is understood that this authorization is given i 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 representative to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization shall remain effective until the end of the school year unless sooner revoked in writing and delivered to the school.

Parent Signature_____ Date _____