BSMFC Athletic Health Record

Blood Pressure: _____

Pulse: _____

TO BE COMPLETED BY PARENT GUARDIAN, PLEASE PRINT ALL INFORMATION IN INK.

LAST NAME: _____ FIRST: _____

AGE: _____ GRADE IN FALL 2020: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE GROUP NAME: _____

POLICY NUMBER: _____

SECONDARY INSURANCE GROUP NAME: _____

POLICY NUMBER: _____

FATHER/GUARDIAN: _____

HOME PHONE: _____ WORK PHONE :_____

CELL/PAGER: _____

MOTHER/GUARDIAN : _____

HOME PHONE: _____ WORK PHONE :_____

CELL/PAGER: _____

FAMILY PHYSICIAN: _____ PHONE: _____

PERSONS TO CONTACT IF PARENTS/GUARDIANS ARE NOT AVAILABLE:

1) _____ PHONE: _____
   RELATIONSHIP: _____
2) _____ PHONE: _____
   RELATIONSHIP: _____

IN THE EVENT OF AN EMERGENCY REQUIRING MEDICAL ATTENTION, I HEREBY GRANT PERMISSION TO ANY PHYSICIAN, DENTIST, OR OTHER MEDICAL PERSONNEL DESIGNATED BY THE BOILING SPRINGS MIDGET FOOTBALL CORPORATION ATHLETIC STAFF TO ATTEND TO MY SON/DAUGHTER IN THE EVENT THAT I AM NOT AVAILABLE. I EXPECT EVERY EFFORT WILL BE MADE TO CONTACT ME TO RECEIVE MY SPECIFIC AUTHORIZATION BEFORE ANY TREATMENT OR HOSPITALIZATION IS UNDERTAKEN. THIS AUTHORIZATION DOES NOT INCLUDE MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH TREATMENT, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

PLEASE SIGN #1 OR #2, DO NOT SIGN BOTH!

1) I GIVE MY PERMISSION FOR THE ATHLETIC STAFF TO ASSESS, TREAT AND REFER AS APPROPRIATELY DETERMINED BY THE ABOVE STATEMENT DURING THE UPCOMING SEASON.
   PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
2) IN THE EVENT EMERGENCY TREATMENT IS NEEDED, I WISH MEDICAL PERSONNEL TO TAKE THE FOLLOWING ACTION:
   _____
   PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Has the athlete ever had, or now have any of the following:

	YES	NO		YES	NO		YES	NO
Asthma			Stomach Trouble			Hearing Difficulty		
Diabetes			Bloody Stool/Urine			Frequent Earaches		
Heart Problems			Injury to Spleen			Problems Breathing		
Dizziness			Hernia			Broken Nose		
Chest Pain			Hepatitis			Nose Bleeds		
Extra Heart Beat			Allergies			Head Injury		
Black Outs			-Medication			-Fracture		
Rheumatic Fever			-Food			-Concussion		
Cancer			-Bites			-Unconsciousness		
Cysts or Lumps			High Blood Pressure			Neck Injury		
Appendicitis			Frequent Headaches			-Fracture		
Seizure Disorder			Nervous Disorder			-Pinched Nerve		

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

_____

Do you take any medicine routinely? (If so, explain): _____

_____

Date of last tetanus shot: _____

Have you ever had surgery? (If so, explain): _____

_____

Have you ever had any problems or surgery to the following paired organs (indicate absence of any organs)

	Yes	No	Explain
Lungs			
Kidneys			
Testes/Ovaries			
Eyes			

Dental & Vision—Do you have:

	Yes	No	Explain
Braces/ Retainer/Other			
Unequal Pupils			
Eye Glasses			
Hard/Soft Contacts			
Glass Eye			

Family Health History—Has any member of the family died from or now have any of the following:

	Yes	No	Explain
Sudden death			
Heart Disease			
High Blood Pressure			
Seizure Disorder			

Orthopedic—Have you ever had, or now have any injury to any of the following (Please note whether injury was to left or right side)

	Yes	No	Explain
Neck			
Shoulder			
Arm/Elbow			
Wrist/Hand/Finger			
Back/Ribs			
Hip/Groin			
Thigh			
Knee			
Lower leg/Shin			
Ankle			
Foot/Toes			
Other			

I certify that the above medical history is accurate and complete and I will report any changes in this information to the coaching staff.

_____

Parent/Guardian Signature Date

Physician Comments:

_____

Physician Signature Date