CAMBRIDGE CENTRAL SCHOOL
MEDICAL INTERIM HEALTH HISTORY & ATHLETIC PERMISSION SLIP

STUDENT NAME_____ SPORT_____ DATE_____
GRADE_____ AGE_____ DATE OF BIRTH_____ DATE ENTERED 9TH GRADE_____
PARENT/GUARDIAN NAME_____ ADDRESS/ZIP_____
HOME PHONE_____ CELL PHONE_____ WORK PHONE_____ E-MAIL_____
EMERGENCY CONTACT_____ PHONE_____
PHYSICIAN'S NAME_____ PHONE_____
INSURANCE CARRIER_____ IDENTIFICATION #_____
ADVANCED PLACEMENT (Grade 7/8 playing JV/Varsity)? NO YES If yes, additional forms must be completed

Within 30 days prior to the start of practice at the beginning of each season, this health history review for each athlete must be completed by the parent/guardian. In the event of illness or injury requiring medical attention by a physician, the athlete will not be allowed to participate until they present a written release from a doctor. An exam within the last year is required for participation.

Please answer the following questions by circling YES or NO;
HAS YOUR CHILD EVER:

1. Within the last year sustained any injury or serious illness which required medical attention including a head injury, loss of consciousness, or burner/stinger (pain from neck to arm)?..... YES NO
   If YES, date when was the problem fully resolved?_____
2. Had a seizure?..... YES NO
3. Complained of chest pain or fainting during physical exertion?..... YES NO
4. Had high blood pressure, a heart murmur, or family history of sudden death before age 50?..... YES NO
5. Been required to wear corrective lenses during sports participation?..... YES NO
   If YES, does he/she wear contact lenses?..... YES NO
6. Been under a physician's care in the past year or taking medication now?..... YES NO
   If YES, please state the diagnosis and medication prescribed_____
7. Had any allergies to medicines, food, insects, etc.?..... YES NO
   If yes, do you have or require an epipen?..... YES NO
8. Had asthma?..... YES NO
   If YES, does your child use an inhaler? Prescription name_____
9. Had impaired or absence of one or both kidneys?..... YES NO
10. Date of Last Tetanus shot_____
11. MALES: Number of testicles_____ FEMALES: Date of onset of menstrual cycle_____
12. Had: Diabetes___ Hepatitis___ Hernia___ Mononucleosis___ Eye Injury___
    Ear Injury___ Headaches___ Stress Fracture___
13. Injured: Ankle___ Back/Neck___ Elbow___ Chest/Ribs___ Foot/Toes___ Hand___ Wrist___
    Fingers___ Hip___ Knee___ Shin___ Calf___ Shoulder___ Thigh___
14. Treatment for any Mental Health Issues?..... YES NO

Please list any additional information where you have answered YES:

_____

PARENT/GUARDIAN - PLEASE READ CAREFULLY AND SIGN

I have read the HEADS UP Concussion Fact Sheet for Parents attached to this form and answered the questions above to the best of my knowledge. My signature below constitutes permission for my child to participate in the above named sport. I also give my consent for my child to receive whatever medical attention (X-Rays, Treatments, Surgery, etc.) that the medical authorities deem necessary for injuries experienced while participating in interscholastic athletics sponsored by Cambridge Central School. I am also aware that certain risks are inherent in athletic participation. Although not probable, serious injuries or even death may occur. In the event of an injury, the school nurse or a physician will be consulted.

PARENT'S SIGNATURE_____ DATE_____

FOR OFFICE USE ONLY (Valid only if signed by the School Nurse or the Athletic Director)

THIS CERTIFIES THAT THE ABOVE NAMED STUDENT ATHLETE IS PHYSICALLY QUALIFIED TO PARTICIPATE IN THE SPORT INDICATED.

DATE OF LAST PHYSICAL EXAM_____ SIGNATURE_____ DATE_____

Original copy on file with the Nurse's Office, copies to Coach (to be carried at all times in First Aid Kit) and on file with the Athletic Director's Office

July 1, 2015