

Swallow School District Athletic Health Form

Name: _____
Grade: _____ Age: _____ Date of Birth: _____
Address: _____
Home phone #: _____ Parents cell phone#: _____
Personal Physician _____ Phone # _____

In Case of Emergency, contact information:

Name: _____ Phone #: _____
Cell #: _____
Insurance carrier: _____ Policy # _____

Swallow School Staff/Parent Coaches, and any of the aforementioned individuals, have the right to release/seek medical attention in the event of an emergency situation.

Parents/Guardian signature: _____ Date: _____

Health Information:

1. Has a doctor ever denied or restricted your participation in sports for any reason?
Yes No
2. Do you have any ongoing medical condition (like diabetes or asthma)?
Yes No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?
Yes No
4. Do you have allergies to medicines, pollens, foods or stinging insects?
Yes No
5. Have you ever passed out or nearly passed out DURING exercise?
Yes No
6. Have you ever passed out or nearly passed out AFTER exercise?
Yes No
7. Do you cough, wheeze, or have difficulty breathing during or after exercise?
Yes No
8. Have you ever used an inhaler or taken asthma medicine?
Yes No
9. Do you have any problems with bones, joints, ligaments or tendons?
Yes No
10. Do you have any heart related problems/defects/symptoms?
Yes No

11. Do you see a doctor for a chronic or ongoing medical problem?

Yes No

12. Have you been diagnosed with a skin infection within the past year?

Yes No

If you have answered “yes” to any of the above questions, please explain your answers in detail. Remember this information is pertinent to pass on to EMT’s in the event of an emergency situation, so please be specific.

If you have a doctor’s order to take any emergency medication such as Epi pens, inhalers, or seizure medication, (etc.) you will need to provide a written physician order for such, and provide the above medication to be kept in the coach’s first aid kit. (Which will travel with the player for away games.) (Medications will be returned at the close of the season). The following is a list of medications my child will be keeping in the coaches first aid kit along with a physician’s order with directions on how and when to use.

If the aforementioned physician is different from the physician ordering the emergency medication please include their name and number:

If you have any other pertinent family medical history to provide or any other information that might keep the players safe and the coaches informed, please include that information here.

I understand that the school’s insurance does not cover any injuries that may occur from this activity.

I agree the above information is accurate and complete and release Swallow School District from any accident/injury/illness related liability.

Parents/Guardian signature: _____ Date: _____