

**MILFORD SCHOOL DISTRICT  
EMERGENCY INFORMATION/HEALTH FORM**

*Please print...*

*(to be completed by Parent/Guardian)*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Town/State \_\_\_\_\_ Zip \_\_\_\_\_ Grade \_\_\_\_\_  
Home Phone# \_\_\_\_\_

***Parent/Guardian***

|                           |                           |
|---------------------------|---------------------------|
| Father _____              | Mother _____              |
| Address _____             | Address _____             |
| Place of Employment _____ | Place of Employment _____ |
| Home# _____ Wk# _____     | Home# _____ Wk# _____     |
| Cell# _____               | Cell# _____               |
| E-mail address: _____     | E-mail address: _____     |

IN CASE OF EMERGENCY WHERE PARENT/GUARDIAN CANNOT BE REACHED,  
PLEASE NOTIFY:

Name of Responsible Person \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

**MEDICAL/HEALTH INFORMATION**

Name of Insurance Company \_\_\_\_\_  
Policy# \_\_\_\_\_ Type of Coverage \_\_\_\_\_

**CONSENT TO PARTICIPATION AND ACKNOWLEDGEMENT OF RISKS**

I hereby acknowledge an awareness that participation in the sport of \_\_\_\_\_ in-  
volves a risk of injury, which may include severe injuries possibly involving paralysis, permanent mental  
disability, or death, and that these injuries may occur in some instances as a result of unavoidable acci-  
dents. I accept these risks in giving consent to participation in \_\_\_\_\_ during the  
\_\_\_\_\_ season by the undersigned athlete.

Athlete's full name and date of birth (please print) \_\_\_\_\_



Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION TO PROVIDE EMERGENCY TREATMENT**

On rare occasions an emergency arises and we are unable to contact the parent/guardian. In order that  
no delay occur that may jeopardize the life of the student, the school requests permission from the parent/  
guardian to seek emergency treatment.

I hereby grant permission to the Milford School District to administer First Aid, administer epineph-  
rine if necessary, secure proper medical treatment and/or hospitalize my son/daughter/ward in case of  
emergency, provided they are unable to communicate with me, and according to their best judgment, fur-  
ther delay might jeopardize the life of my son/daughter/ward.



Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH QUESTIONNAIRE FOR SPORTS PARTICIPATION

*Please answer each question below. Those marked yes, please explain below to the best of your ability.*

Circle One

- |  |    |     |
|--|----|-----|
| 1. Have you ever been in a hospital for an operation or other reason?                              | NO | YES |
| 2. Do you take any kind of medicine every day?   | NO | YES |
| 3. Do you have asthma or allergies (hives, medicine, bee sting?)                                   | NO | YES |
| 4. Are you under a physician's care for any problems now?  | NO | YES |
| 5. Have you ever felt dizzy or had chest pains during or after exercise?                           | NO | YES |
| 6. Do you have a heart murmur or other heart conditions?   | NO | YES |
| 7. Have you ever fainted or "blacked out" during exercise?   | NO | YES |
| 8. Have you ever had a heat illness such as heat exhaustion or stroke?                             | NO | YES |
| 9. Have you ever had a concussion or suffered loss of consciousness or memory?                     | NO | YES |
| 10. Have you ever had a fracture, dislocation, sprain, strain or other injury to<br>any body part? | NO | YES |
| 11. Do you have any eye problems, wear glasses or contacts?  | NO | YES |
| 12. Have you ever been told not to participate in any sport?                                       | NO | YES |

EXPLAIN "YES" ANSWERED QUESTIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE OF LAST TETANUS BOOSTER: \_\_\_\_\_

### PARENT/GUARDIAN PERMISSION FOR SPORTS PARTICIPATION

I hereby agree that the above statements of medical history are accurate, and give my consent for this student to participate in (Check one):

All approved school athletics    Specific sport



Signature \_\_\_\_\_ Date signed \_\_\_\_\_

### PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

**I, the parent/guardian, or student 18 years of age or older, authorize the Principal to direct and assign members of the school staff to assist the above named child in taking the following medication. I agree to not hold responsible any member of the school staff or an individual or official capacity who is directed by myself and the Principal to assist the above named student in taking said medication.**

Acetaminophen (Tylenol) \_\_\_\_\_ Ibuprofen (Advil) \_\_\_\_\_ Antacid \_\_\_\_\_



Parent/Guardian Signature \_\_\_\_\_

# Physical Examination For Sports Participation

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medication(s): \_\_\_\_\_

*This young person is going to enter a program of strenuous activity. In addition to a brief assessment of general health, the following specific items should be noted:*



**DATE OF EXAM:** \_\_\_\_\_

RECOMMENDATION:

| ITEM<br>Specially Note            | AGE | ITEM<br>Specially Note                    | HT:<br>Pulse: | WT:<br>B/P: |
|-----------------------------------|-----|---|---------------|-------------|
| SKIN<br>ACENE-Herpes-Ath.Foot     |     | ABDOMEN<br>Organomegaly                   |               |             |
| MOUTH<br>Caries-Prosthesis        |     | GENITALIA(MALES)<br>Lesions-Testes-Hernia |               |             |
| EYES-EARS<br>Pupils/Perf.-Dischrg |     | MUSCULOSKELETAL SCREEN<br>See Guidelines: |               |             |
| LUNGS<br>AIR ENTRY - Wheezing     |     | TANNER MATURITY<br>Circle one: 1 2 3 4 5  |               |             |
| HEART<br>Murmur-Rhythm-Size       |     | OTHER OBSERVATIONS                        |               |             |
|                                   |     |   |               |             |

CHECK ONE AND SIGN:                     FULL PARTICIPATION APPROVAL  
      LIMITED: \_\_\_\_\_

RECOMMENDATIONS  
 PHYSICIAN'S SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## PERIODIC MEDICAL HISTORY UPDATE



NOTES:

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