ATHLETIC INFORMATION

*COACHES: Please make a copy of the Emergency Medical Form (both sides) and keep for your records.
(RETURN THIS ENTIRE PACKET TO THE ATHLETIC DEPARTMENT)

Last Name_____

First Name_____

Grade _____

Birth Date _____

Date Entered East Knox High School_____

Example: Senior = 8/20/11 Junior = 8/20/12 Sophomore = 8/20/13 Freshman = 8/20/14
If you moved into the school district while in high school use the date of the first day you attended school at East Knox High School.

Are you open enrolled to East Knox High School?_____

If yes, what school did you attend last year? _____

Did you move into the district after the 5th day of your 9th grade year? _____

If yes, have you met with the Athletic Director to fill out the appropriate paperwork?_____

I have read and understand the rules, regulations and expectations provided in the Athletic Handbook. As an athlete, I will follow these rules knowing that failure to do so will result in denial of participation from athletics at East Knox High School.

Print Name_____

Student Signature _____

Date _____

Parent signature_____

Date _____

Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2014-2015

HISTORY FORM

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner. The medical examiner should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Address _____

Emergency Contact: _____ Relationship _____

Phone (H) _____ (W) _____ (Cell) _____ (Email) _____

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) that you are currently taking

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____		
3.	Have you ever spent the night in the hospital?		
4.	Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		**Yes**	**No**
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7.	Does your heart ever race or skip beats (irregular beats) during exercise?		
8.	Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9.	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?		
11.	Have you ever had an unexplained seizure?		
12.	Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		**Yes**	**No**
13.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arryhthmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS		**Yes**	**No**
17.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18.	Have you ever had any broken or fractured bones or dislocated joints?		
19.	Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20.	Have you ever had a stress fracture?		
21.	Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		

BONE AND JOINT QUESTIONS - CONTINUED		Yes	No
22.	Do you regularly use a brace, orthotics, or other assistive device?		
23.	Do you have a bone, muscle, or joint injury that bothers you?		
24.	Do any of your joints become painful, swollen, feel warm, or look red?		
25.	Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS		Yes	No
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27.	Have you ever used an inhaler or taken asthma medicine?		
28.	Is there anyone in your family who has asthma?		
29.	Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30.	Do you have groin pain or a painful bulge or hernia in the groin area?		
31.	Have you had infectious mononucleosis (mono) within the past month?		
32.	Do you have any rashes, pressure sores, or other skin problems?		
33.	Have you had a herpes (cold sores) or MRSA (staph) skin infection?		
34.	Have you ever had a head injury or concussion?		
35.	Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?		
36.	Do you have a history of seizure disorder or epilepsy?		
37.	Do you have headaches with exercise?		
38.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39.	Have you ever been unable to move your arms or legs after being hit or falling?		
40.	Have you ever become ill while exercising in the heat?		
41.	Do you get frequent muscle cramps when exercising?		
42.	Do you or someone in your family have sickle cell trait or disease?		
43.	Have you had any problems with your eyes or vision?		
44.	Have you had an eye injury?		
45.	Do you wear glasses or contact lenses?		
46.	Do you wear protective eyewear, such as goggles or a face shield?		
47.	Do you worry about your weight?		
48.	Are you trying to gain or lose weight? Has anyone recommended that you do?		
49.	Are you on a special diet or do you avoid certain types of foods?		
50.	Have you ever had an eating disorder?		
51.	Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY			
52.	Have you ever had a menstrual period?		
53.	How old were you when you had your first menstrual period?		
54.	How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student_____ Signature of parent/guardian_____ Date: _____

The student has family insurance ☐ Yes ☐ No If yes, family insurance company name and policy number: _____

THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1.	Type of disability		
2.	Date of disability		
3.	Classification (if available)		
4.	Cause of disability (birth, disease, accident/trauma, other)		
5.	List the sports you are interested in playing		
		Yes	**No**
6.	Do you regularly use a brace, assistive device or prosthetic?		
7.	Do you use a special brace or assistive device for sports?		
8.	Do you have any rashes, pressure sores, or any other skin problems?		
9.	Do you have a hearing loss? Do you use a hearing aid?		
10.	Do you have a visual impairment?		
11.	Do you have any special devices for bowel or bladder function?		
12.	Do you have burning or discomfort when urinating?		
13.	Have you had autonomic dysreflexia?		
14.	Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
15.	Do you have muscle spasticity?		
16.	Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student_____ Signature of parent/guardian_____ Date: _____

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet or use condoms?
   - Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION	DATE OF EXAMINATION	
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L20/ Corrected ☐ Y ☐ N	
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat Pupils equal Hearing		
Lymph nodes		
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck walk, single leg hop		

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not Cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type) _____ Date of Exam _____

Address _____ Phone _____

Signature of physician/medical examiner _____, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician _____ Phone _____

In case of Emergency, contact _____ Phone _____

Allergies _____

_____

_____

_____

_____

_____

Other Information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

OHSAA AUTHORIZATION FORM 2014-2015

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

_____

Student's Signature — Birth date of Student, including year

_____

Name of Student's personal representative, if applicable

I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

_____

Signature of Student's personal representative, if applicable — Date

A copy of this signed form has been provided to the student or his/her personal representative

2014-2015 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

I have read, understand and acknowledge receipt of the **OHSAA Student Athlete Eligibility Guide** which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA web site at www.ohsaa.org.

I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

I understand that participation in interscholastic athletics is a **privilege not a right**.

Student Code of Responsibility

As a student athlete, I **understand and accept** the following responsibilities:

- I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.
- I will be **fully responsible** for my own actions and the consequences of my actions.
- I will **respect the property** of others.
- I will **respect and obey the rules** of my school and laws of my community, state and country.
- I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.
- I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.

To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or guardian(s), residence address of the student, academic work completed, grades received and attendance data.

I **consent to the OHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

I **understand that if I drop a class**, take course work through Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I **have read and signed** the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature	Birth date	Grade in School	Date

Parent's or Guardian's Signature	Date

East Knox Athletic Department

Athletic Insurance Waiver Form

Rule Four: Insurance Prior to First Practice

All students participating in the athletic program must be covered by an accident insurance policy in one of two ways before being permitted to participate in practice.

1. A school insurance waiver form signed by the parents stating they have adequate insurance coverage on file in the athletic director's office.
2. Purchase school insurance: Individual students needing information on school insurance may pick up forms in the main office or obtain the forms from their coach.

If you purchase insurance, all money and forms are to be returned by the parent directly to the insurance provider, Gordon Griffin. The school does not act as an agent for the insurance provider.

Check one of the following:

Football Insurance

1. ____ My son has football coverage through our family policy.

   Name of insurance provider: _____

2. ____ My son has no family insurance coverage for football, therefore we want to have the school coverage and have taken the necessary steps to apply for the necessary insurance.

Athletic Insurance other than Football

3. ____ My son/daughter has no family insurance coverage that covers athletics, therefore we want to take the school coverage and have taken the necessary steps to apply for plan 1 (24 hour coverage which would include athletics other than tackle football).

4. ____ My son/daughter has insurance coverage through our family policy which includes athletics.

   Name of insurance provider:_____

Parent/Guardian Signature _____Date_____

East Knox Athletic Department

Waiver of Liability During Unscheduled Time After School Hours

Parents are here by notified that the school does not assume responsibility for the supervision of student-athletes from the end of the regular school day until the start of the scheduled practiced.

Practice schedules will be provided to the student athlete. In the event the athlete does not have practice directly after school, it becomes the responsibility of the home to make appropriate arrangements for supervision during the unscheduled time and any necessary transportation to and from school.

Students are to exit the school within 15 minutes after the bell unless under the direct supervision of a coach or advisor.

I have read this waiver of liability.

_____ _____

Parent Signature Date

_____ _____

Student/Athlete Signature Date

INFORMED CONSENT AGREEMENT

We hereby consent to allow the student named on the reverse side to undergo urinalysis testing for the presence of illicit drugs, alcohol, or banned substances in accordance with Policy and Procedures for Drug Testing of the EAST KNOX SCHOOLS District.

We understand that testing will be administered in accordance with the guidelines of the EAST KNOX SCHOOLS District Drug Testing Policy for student athletes and competitive extra curricular activities.

We understand that any urine sample taken for drug testing will be tested only by a Board approved company.

We hereby give our consent to the company selected by the EAST KNOX SCHOOLS Board of Education, its employees, or agents, together with any company, hospital, or laboratory designated to perform urinalysis testing for the detection of drugs.

We further give our consent to the company selected by the EAST KNOX SCHOOLS Board of Education, its employees, or agents, to release all results of these tests to designated School District employees or agents. We understand that these results will also be available to us upon request.

I, the student, hereby authorize the release of the results of such testing to my parent/guardian/ custodian.

We hereby release the EAST KNOX SCHOOLS Board or Education, its employees or agents from any legal responsibility or liability for the release of such information and records.

This will be deemed a consent pursuant to the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. 1232g as amended, and the Ohio Revised Code 3319.321, for the release of the test results as authorized by the Informed Consent Agreement or as required by law.

EAST KNOX SCHOOLS INFORMED CONSENT AGREEMENT

STUDENT NAME _____ GRADE _____

AS A STUDENT:

- I understand and agree that participation in athletic and competitive extra curricular activities is a privilege that may be withdrawn for violations of the EAST KNOX SCHOOLS Drug Testing Policy.
- I have read the Drug Testing Policy and thoroughly understand the consequences that I will face if I do not honor my commitment to the Drug Testing Policy.
- I understand that when I participate in any athletic or competitive extra curricular program I will be subject to initial and random urine drug & alcohol testing, and if I refuse, I will not be allowed to practice or participate in any activities. I have read the informed consent agreement and agree to its terms.
- I understand this agreement is binding while I am a student in the EAST KNOX SCHOOLS system.

_____ _____

STUDENT SIGNATURE DATE

AS A PARENT/GUARDIAN/CUSTODIAN:

- I have read the EAST KNOX SCHOOLS district drug testing policy and understand the responsibilities of my son/daughter/ward as a participant in athletic and/or competitive extra curricular activities in the EAST KNOX SCHOOLS district.
- I pledge to promote healthy lifestyles for all student athletes and/or competitive extra curricular in the EAST KNOX SCHOOLS system.
- I understand that my son/daughter/ward, when participating in any athletic program and/or competitive extra curricular group, will be subject to initial and random urine drug and alcohol testing, and if he/she refuses, will not be allowed to practice or participate in any of the group/team activities. I have read the informed Consent Agreement and agree to its terms.
- I understand this agreement is binding while my son/daughter/ward is a participant in athletics and/or competitive extra curricular activities in the EAST KNOX SCHOOLS district.

_____ _____

PARENT/GUARDIAN/CUSTODIAN SIGNATURE DATE

_____ _____

PARENT GUARDIAN/CUSTODIAN PRINTED NAME WORK PHONE

Form must be completed by an Adult and returned by SEPTEMBER 1ST.

EAST KNOX SCHOOLS

STUDENT EMERGENCY MEDICAL FORM

Date_____, Bus #____, Grade_____

STUDENT NAME

Last Name:_____ **First Name:**_____ **MI.**___ **DOB:**_____

Student Address:_____**City/State:**_____**Zip:**_____

Student Cell Phone:_____

MOTHER/GUARDIAN

Last Name:_____ First Name:_____ Suffix:_____

Phone Home:_____ Cell_____ Work_____

FATHER/GUARDIAN

Last Name:_____ First Name:_____ Suffix:_____

Phone Home:_____ Cell_____ Work_____

OTHER EMERGENCY CONTACTS: (TWO alternate WORKING/in service numbers ARE REQUIRED)

Last Name:_____ First Name:_____ Suffix:___ Relationship: _____

Phone Home:_____ Cell_____ Work_____

Last Name:_____ First Name:_____ Suffix:___ Relationship: _____

Phone Home:_____ Cell_____ Work_____

Last Name:_____ First Name:_____ Suffix:___ Relationship: _____

Phone Home:_____ Cell_____ Work_____

Last Name:_____ First Name:_____ Suffix:___ Relationship: _____

Phone Home:_____ Cell_____ Work_____

I hereby give my consent, in the event that all reasonable attempts to contact me have been unsuccessful, for: 1) the administration of any treatment deemed necessary by Doctor_____ phone number _____ or in the event that the appropriate preferred practitioner is not available, by another licensed physician or dentist and transfer of the student to the NEAREST HOSPITAL.

Preferred Dentist _____ at phone number _____.

The following information is REQUIRED:

Physical Impairments/Medical Conditions _____ Last Tetanus Shot _____

Medication being taken _____

Other pertinent facts to be alerted to_____ Allergies_____

Signature of Parent/Guardian_____ **Date** _____

(If refuse to consent, you must STILL complete ENTIRE form.)

Refuse to consent for Doctor and Hospital Treatment ☐ Signature _____ Date_____

Please complete reverse side

Form must be completed by an Adult and returned by SEPTEMBER 1ST.

EAST KNOX SCHOOLS

STUDENT HEALTH HISTORY

Student Name:_____

Record of illness and health problems (check disease or health problem) to which the student is subject to or has had (please comment at bottom if necessary).

Chicken Pox	_____	Rheumatic Fever	_____	Convulsion/Seizures	_____
Mononucleosis	_____	Hearth Disease	_____	Fainting Spells	_____
Diabetes	_____	Asthma	_____	Bladder or Kidney Problems	_____
Headaches	_____	Allergies	_____	Paralysis or Muscle Weakness	_____
Migraines	_____	(Allergic to, specify:)		Juvenile Arthritis	_____
ADHD	_____	_____		Cerebral Palsy	_____

	Yes	No	Please Describe
Does student have a			
Vision problem			
Hearing problem			
Speech/Language problem			
Learning problem			
Sever allergic reaction, please describe			
Is an Epi-pen or other medicine need for reaction?			
Other illness or health problems, please describe.			
Is there any tendency in your family towards a specific health problem?			
Is student taking any prescribed medication?			
What is the medication being taken for?			
Does student have any unusual reactions to injury or illness?			

Has the student had any serious injuries or operations?_____

_____

Are there any restrictions on the student's participation in school activities?_____

_____

Are there any restrictions regarding the administration of first aid?_____

If you want to discuss any of your child's health problems, please call the school nurse.

Additional Comments:_____

_____

_____

I **approve** or **disapprove** to have my child's picture published in the newsletter/annual report-calendar.
Circle appropriate

I **approve** or **disapprove** to have my child's picture published on the East Knox Website. (Child's name withheld).
Circle appropriate

Residential Parent/Guardian Signature _____ Date _____