ROCKY HILL HIGH SCHOOL ATHLETIC DEPARTMENT
REGISTRATION/MEDICAL CONSENT/PHYSICIANS STATEMENT FORM

STUDENT:_____ **Grade:**_____
LAST NAME FIRST M.I. M/F D.O.B.

ADDRESS:_____

_____**HOME TELEPHONE:**_____ **CELL:**_____

PARENT/GUARDIAN:_____**WORK PHONE:**_____

(To be completed by Student and Parent/Guardian)

1. Do you have any allergies (drug, food, insect stings, etc)? Yes____ No____
2. Do you require an Epipen? Yes____ No____
3. Are you currently taking drugs or medications (include steroids,inhalers,and supplements)? Yes____ No____
4. Are you being treated for any condition by a physician or other health professional? Yes____ No____
5. Have you ever been advised by a doctor not to participate in sports? Yes____ No____
6. Do you have any chronic conditions or diseases (i.e. asthma, diabetes, etc) Yes____ No____
7. Have you ever suffered a concussion or head injury? Yes____ No____

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

8. Have you ever been hospitalized for medical or surgical reasons? Yes____ No____
   If yes, please provide the following information:
   Reason:_____ Year_____
9. Please list below any injury that you have had which prevented you from participating in regular life activities for one week or More.
   Injured area: _____ Year_____ Type of Injury_____

I/we hereby state that we have reviewed this medical history and certify that the information supplied above is correct. I/we give permission for the above named student to participate in all sports including contact sports.

_____ _____
(student signature) (date) **(parent/guardian signature) (date)**

(To be completed by Physician)

Please check if normal findings: Respiratory_____ Orthopedic_____ HEENT_____
Cardiovascular (arrhythmia, murmur)_____ Neurological_____

Please indicate below any known conditions, illnesses, allergies, or prior injuries, which could affect or limit participation in sports and/or medical treatment:

_____
_____

I herby certify that _____is in good health and physically able to participate in all sports including contact sports. This certificate is valid for the school year 2008-2009 unless voided by any serious injury or illness.

_____
_(Physician's Name) PLEASE PRINT (Physician's Signature) (Date)

THIS COMPLETED FORM IS TO BE PRESENTED TO THE DIRECTOR OF ATHLETICS DURING THE PRESEASON REGISTRATION PERIOD.