NORDHOFF HIGH SCHOOL

Parent Consent form and Sports Exam Information 2017-18 (PLEASE PRINT)

Student Name______________________________ Sports____________________ Grade_______

Address____________________________________ City____________________ Zip__________

Birthdate_____________________ Gender_____ ParentPhone/email_____________________________

NAME OF THE ***INSURANCE COMPANY*** THAT COVERS THE ATHLETE ACCORDING TO STATE LEGAL REQUIREMENTS:

____

NAME OF INSURANCE (Insurance is required by the State of California to participate in High School Athletics)

I GIVE MY PERMISSION FOR MY CHILD TO BE EXAMINED TO DETERMINE FITNESS FOR ATHLETIC COMPETITION

____ __________________________________

Parent Signature Date

Health History: To be completed by parent before doctor exam.

Any past or present:	Yes	No
Problems with vision	____	____
Eyeglasses	____	____
Contacts	____	____
Problems with hearing	____	____
Hearing Aid	____	____
Blacking Out or fainting	____	____
Unconsciousness	____	____
Convulsions, seizures	____	____
Ear problems	____	____
Bleeding Disorders	____	____
Blood sugar problems	____	____
Hypoglycemia	____	____
Diabetes	____	____
Asthma	____	____
Allergies-Type________________________		
Bee or insect stings	____	____
Hospitalizations	____	____
Surgeries	____	____
Hernias	____	____

	Yes	No
Dental problems	____	____
braces	____	____
false teeth	____	____
Painful Joints	____	____
Broken Bones	____	____
Part, date____________________		
Knee or ankle problems	____	____
require support or brace	____	____
Need for medications	____	____
Name/Type_________________________		
Female menstruation problems	____	____

ANY OTHER HEALTH ASPECT DOCTOR AND SCHOOL SHOULD BE AWARE OF:

____

____

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____

PHYSICAL EXAM: Name of Family physician_________________________________Phone_______________

Eyes	______	Lymph Glands	______	Posture	______	Abdomen	______	Nose	______
Ears	______	Thyroid	______	Muscle Tone	______	Hernia	______	Blood Pressure	______
Reflexes	______	Skin	______	Throat	______	Lung	______	Athlete's Foot	______
Teeth	______	Braces	______	Orthopedic	______	Heart	______		

I have examined the above named student and so recommend that he/she is physically fit for full participation in sports.

Signature____ Date___________________

Special doctor recommendation or restrictions____