MEDICAL HISTORY FORM

Last Name	First Name	D.O.B.	Grade

I. PARENTS PERMISSION

I hereby give my consent for the above named (son/daughter/ward) to compete in the interscholastic sport of ______________ and to travel with the team using transportation that qualifies under the North Attleborough Public Schools regulations. I also understand that, in case of injury, the person in charge of the team is authorized to have him/her treated. I also recognize that my son/daughter is subject to the High School discipline code and to Athletic Department rules and regulations and team training rules and that failure to abide by these rules may result in his/her being removed from athletic participation at North Attleboro High School.

Date ______________ Parent/Guardian Signature ______________

II. INSURANCE SECTION

North Attleboro High School will provide a secondary, but limited, accident coverage for all athletes. All benefits under this plan are only payable after all other collectible insurance, or other valid coverages have been paid. HMO service must be rendered by the plan provider. The balance of any unpaid, and eligible medical expenses for which the parent is responsible will then be paid up to the limits of the policy. This insurance is non-duplicating.

III. A CLAIM MUST BE FILLED WITH ALL OTHER INSURANCE SOURCES:
IT IS THE PARENTS' RESPONSIBILITY TO FILE A CLAIM FORM IMMEDIATELY WITH THE SCHOOL NURSE OR ATHLETIC DIRECTOR.

Name of Parents' Insurance Plan ______________ Parent/Guardian Signature ______________

Parent/Guardian Name ______________ Cell Phone Number ______________
Home Phone Number ______________ Work Phone Number ______________

Emergency Contact Name ______________ Cell Phone Number ______________
Home Phone Number ______________ Work Phone Number ______________
Relationship to Student ______________

BE SURE **ALL** FORMS ARE COMPLETELY FILLED OUT, INCLUDING STUDENT AND PARENT/GUARDIAN SIGNATURES.

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		Yes	No
1.	Have you ever been told not to participate in any sport for health reasons?	___	___
2.	Have you ever fainted or passed out during exercise or stopped exercising because of dizziness?	___	___
3.	Has anyone in your immediate family died suddenly before the age of 50?	___	___
4.	Do you have asthma (wheezing), coughing spells or shortness of breath during or after exercise?	___	___
5.	Have you ever had a concussion, lost consciousness (been "knocked out")? or had memory loss after a head injury?	___	___
6.	Are you now being treated for or have you ever been treated for any of the following: bleeding disorder, convulsions or seizures, diabetes, chronic headaches, heart disease (including murmur, irregular heartbeat or surgery), high blood pressure, kidney disease, liver disease, collapsed lung?	___	___
7.	Are you missing sight in one eye, hearing in one ear, or have only one testicle or kidney?	___	___
8.	Have you ever had a neck or back injury/problem (including "stingers" or "burners")?	___	___
9.	Have you ever broken (fractured) a bone or had to wear a cast or splint?	___	___
10.	Have you ever had an ankle or knee sprain, or dislocated a joint?	___	___
11.	Have you had any other serious injuries?	___	___
12.	Have you ever suffered heat exhaustion, heat stroke, or had other problems related to heat?	___	___
13.	Have you ever been in the hospital overnight or had an operation?	___	___
14.	Do you wear contact lenses, eyeglasses or use a hearing aid?	___	___
15.	Do you have allergies to medicines or bee stings?	___	___
16.	Do you take any medicine regularly, either prescription or non-prescription?	___	___
17.	Are you currently being treated for an illness by a doctor or other health care professionals?	___	___
18.	Do you have any worries about your health or other questions you would like to discuss?	___	___

Explain any "yes" answers to the above:____

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