CORCORAN HIGH SCHOOL ATHLETIC PARTICIPATION CARD
PHYSICIAN'S STATEMENT AND PARENT'S CONSENT

STUDENT'S NAME (Please Print)

____

(Last) (First) (Middle Initial)

My son/daughter has permission to participate in athletics at Corcoran High School and to travel with his/her team(s) for athletic contests. Should it be necessary for my child to have medical treatment while participating in sports, or on a trip, and if the District is unable to contact me, I hereby authorize Corcoran Unified School District personnel to use their judgment in obtaining medical services for my child. I understand as parent/guardian I must provide medical insurance for my child. I am aware this information will be shared with coaches and other school personnel, or emergency/medical persons who need the information.

Parent/Guardian ____(signature required) Date:____________________

Phone number(s)______________________________Work ____________________ cell #______________________

HEALTH HISTORY

To be completed by Parent/Guardian (Answer "Yes" or "no" only)

STUDENT NAME______________________________SEX: M / F AGE:________ BIRTHDATE__________________

	Yes	No		Yes	No
1. Chronic/Recurrent Illness	____	____	12. Asthma or Wheezing	____	____
2. Surgery other than Tonsils	____	____	13. Chest Pain	____	____
3. Injuries treated by physician	____	____	14. Problems with blood	____	____
4. Under care of physician for current condition	____	____	15. Problems with liver, spleen, kidneys	____	____
5. Currently taking medication	____	____	16. Hernia	____	____
6. Organs missing	____	____	17. Bone/joint injury	____	____
7. Heat exhaustion or heat stroke	____	____	18. Allergy to medications	____	____
8. Dizziness, faint, convulsions, chronic headache	____	____	19. Immunizations current	____	____
9. Knocked out or unconscious	____	____	20. Tetanus booster last 10 years	____	____
10. Diabetes	____	____	21. Family history or unexplained sudden death before age 50.	____	____
11. Contacts or corrective lenses	____	____			

If you answered "yes" to any above, please explain

____

In order for student to participate in sports, proof MUST be shown that student has received a DtaP, Tdap or DTP vaccination on or after the 7th birthday. This is a new State Requirement.

PHYSICAL SCREENING

(To be completed by physician)

HT _____________WT_____________BP________________UA(optional) ________VISION__________

GENERAL_________________CHEST_____________HEART____________ABDOMEN____________

GU/HERNIA_______________NECK/BACK___________________EXTREMITIES_________________

LIMITATIONS: Yes____ No_____ If "yes", list limitations below in the Summary of Comments area.

SUMMARY OF COMMENTS:____

____

____

I VERIFY THAT ___________________HAS BEEN EXAMINED BY ME ON______________________ and is physically able to participate in interscholastic athletics.

PHYSICIAN NAME_________________________PHYSICIAN'S SIGNATURE_____________________

Phone #______________________

Revised May 2011