SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Participant's Name _____

Participant's Date of Birth _____/_____/_____

Current Physical Address _____

Participant Cell Phone # _____

Participant Home Phone # _____

EMERGENCY INFORMATION

Parent/Guardian Name _____

Relationship _____ Cell Phone Number _____

Address _____

City/State/Zip _____

Parent/Guardian E-mail Address _____

Secondary Emergency Contact Name _____

Relationship _____ Cell Phone Number _____

Address _____

City/State/Zip _____

INSURANCE & PHYSICIAN INFORMATION

Medical Insurance Carrier _____

Subscriber Name _____ Subscriber Date of Birth _____/_____/_____

ID Number _____ Group Number _____

Insurance Company Phone Number _____

Family Physician's Name _____

Address _____

City/State/Zip _____

Phone Number _____

SECTION 2: ALLERGIES, MEDICATIONS, AND SUPPLEMENTAL HEALTH HISTORY

Participant's Allergies _____

Participant's Prescription Medications and conditions for which they are being prescribed:

_____

_____

_____

Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware:

_____

_____

_____

If any SUPLLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named participant shall submit a completed Re-Certification Form (Section 3) to the LVASFC Board.

Explain "Yes" answers at the bottom of this form.

1. Since completion of your most recent pre-participation physical, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine? If serious illness or serious injury was marked "Yes," please provide additional information below.	Yes ☐ No ☐
2. Since completion of your most recent pre-participation physical, have you had a concussion (i.e., bell rung, ding, head rush) or traumatic brain injury?	Yes ☐ No ☐
3. Since completion of your most recent pre-participation physical, have you experienced dizzy spells, blackouts, and/or unconsciousness?	Yes ☐ No ☐
4. Since completion of your most recent pre-participation physical, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	Yes ☐ No ☐
5. Since completion of your most recent pre-participation physical, are you taking any NEW prescription medicines or pills?	Yes ☐ No ☐
6. Do you have any concerns that you would like to discuss with a physician?	Yes ☐ No ☐

#'s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Participant's Signature _____ Date _____/_____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent/Guardian Signature _____ Date _____/_____/_____

RE-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE

This Form must be completed for any participant who required medical treatment from a licensed physician of medicine or osteopathic medicine after their most recent preparticipation physical. This Form may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to LVASFC Board who shall exclude any participant who has suffered serious illness or injury until that participant is pronounced physically fit by a licensed physician of medicine or osteopathic medicine.

NOTE: The physician completing this Form must first review Section 2 of the herein named participant where the herein named participant either checked yes or circled any Supplemental Health History.

If the physician completing this Form is clearing the herein named participant subsequent to that participant sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Participant's Name _____

Condition(s) Treated Since Completion of the Herein Named Participant's Most Recent Physical Examination CIPPE

_____

_____

_____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified participant to participate in athletics with no restrictions, except those, if any, set forth below.

Restrictions (if any) to athletic participation: _____

_____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified participant to participate in athletics with the following limitations/restrictions set forth below:

1. _____
2. _____
3. _____
4. _____

Physician's Name _____ License # _____

Address _____

City/State/Zip _____ Phone _____

Physician's Signature _____ MD/DO (*circle*) Date _____/_____/_____