Argyle Student-Athlete Medical Form

|  |  |  |
| --- | --- | --- |
| **Name of Student:**      | **Grade:**      | **M/F:**      |
| **School: Argyle Secondary School** |
| **Care Card Personal Health No:**       | **Birthdate (DDMMYY:)**       |
| **Family Doctor:**       | **Dr. Phone:**       |
| **Parent/Guardian Name:**  |
| **Address:**       | **Postal Code:**       |
| **City:**       |
| **Phone (H)**       | **(W)**       | **(M)**       |

Please note any health condition, physical handicap, emotional difficulty, behaviour problem, or other factors that may limit full participation in this program:

Has the student had a previous injury that would require special first aid treatment should another injury occur?

The student has received the regular immunization program administered in BC for: Diphtheria; Pertussis & Tetanus DPT; Tetanus and Diphtheria (TD); Polio; Measles, Mumps and Rubella (MMR)

***Yes*** [ ]  ***No*** [ ]

If no, please explain:

Does the student wear Contact Lenses: ***Yes*** [ ]  ***No*** [ ]

Student is subject to:

[ ]  asthma [ ]  eye infections [ ]  motion sickness [ ]  sinus problems

[ ]  bronchitis [ ]  fainting [ ] muscle pulls [ ]  sleep walking

[ ]  dislocations [ ]  frequent colds [ ]  nose bleeds [ ]  sprains

[ ]  dizziness [ ]  headaches [ ]  seizures [ ]  tonsillitis

[ ]  ear aches [ ]  high blood pressure [ ]  sensitive skin

[ ]  kidney problems

[ ]  severe allergies/anaphylaxis (provide detail:      )

[ ] Other conditions and/or \*further detail (describe below or attach separate sheet)

***Alternate Emergency Contacts***:

|  |  |
| --- | --- |
| **Name:**       | **Phone:**       |
| **Name:**       | **Phone:**       |

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND ON FILE*