Argyle Student-Athlete Medical Form

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| --- | --- | --- | --- | --- | --- |
| **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*