Argyle Student-Athlete Medical Form

Name of Student: _____ Grade: _____ M/F: _____

School: **Argyle**

Care Card Personal Health No. _____Birth Date (DDMMYY): _____

Name of Parent/Guardian:_____

Address: _____Postal Code:_____

Phone (Mobile) _____ (Work) _____(Home) _____

Please note any physical or health condition, 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? Ie. Concussion, joint separation, fracture, bleeding

_____

_____

_____

Does the student wear Contact Lenses: Yes No (circle)

Student is subject to:

( ) asthma ( ) eye infections ( ) motion sickness ( ) sinus problems

( ) bronchitis ( ) fainting ( ) muscle pulls

( ) dislocations ( ) frequent colds ( ) nose bleeds ( ) sprains

( ) dizziness ( ) headaches ( ) seizures ( ) tonsillitis

( ) ear aches ( ) high blood pressure ( ) sensitive skin

( ) kidney problems ( ) severe allergies/anaphylaxis (to: _____)

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

Alternate Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

Parent/Guardian Signature _____ Date: _____

THIS INFORMATION WILL BE KEPT CONFIDENTIAL and DESTROYED AFTER CONCLUSION OF THE SEASON