Central Kitsap School District
Medical History and Waiver - Emergency Reference

Name:_____ M ☐ F ☐ DOB: _____ Grade:_____ Sport:_____
(Last) (First) (MI)

Address: _____ _____
(Street) (City) (State) (Zip) Parent/Guardian Home Telephone

Parent/Guardian Name: _____ Work #_____ Cell: _____ Email: _____

Parent/Guardian Name: _____ Work #_____ Cell: _____ Email: _____

Emergency contact #1: _____ Telephone (H/W): _____

Emergency contact #2: _____ Telephone (H/W): _____

Athlete's physician: _____ Telephone: _____

Insurance Carrier: _____ Policy Holder's Name: _____

MEDICAL HISTORY: Check "Yes" or "No"
Additional details to questions answered "Yes" listed under the Comments section.

Has any medical condition, which may affect athletic participation. Yes ☐ No ☐

Describe: _____

Has had injuries/illness lasting more than one week in the last year. Yes ☐ No ☐

Describe: _____

Has any food, pollen or drug allergy. Yes ☐ No ☐

List allergy(s) and describe the severity of reaction: _____

Is presently taking medication of any kind. Yes ☐ No ☐

List medication: _____ Self-medicated: Yes ☐ No ☐

Is presently under a physician's care. Yes ☐ No ☐

Describe: _____ Date Released to Participate: _____

Check all that apply: High blood pressure ☐ Heart disease ☐ Organ abnormalities ☐

Has a history of a concussion, seizure, epilepsy or headaches: Yes ☐ No ☐

Has been medically diagnosed with heat exhaustion/stroke: Has Yes ☐ No ☐

been professionally diagnosed with exercise induced asthma: Yes ☐ No ☐

Describe the severity of reaction: _____

Has been hospitalized for injury or illness. Yes ☐ No ☐

Describe: _____ Date: _____

Has had any injury or illness requiring medical attention in the past three years. Yes ☐ No ☐

Describe: _____ Date: _____

Has been immunized for Tetanus: Yes ☐ No ☐ Date: _____

COMMENTS:

The information provided above is accurate. In the event of injury or illness, the athlete stated above may be transported to a medical facility for care. As the legal authority of the above person, I hereby give my permission to medical personnel to provide treatment as needed. I understand and agree that medical information may be shared with other healthcare professionals.

Parent/Guardian Signature: _____ Date: _____