West Ranch High School Athletics
Emergency Card

Student Last Name_____Student First Name_____Birthdate_____

Sport(s)_____ Grade_____ Student Email_____

Street Address _____ Apt_____

City_____Zip Code_____Home Phone_____

Transfer from another High School _____YES _____ NO If YES, what school and when

_____

Mother's Name Cell Phone # Home Phone # Work Phone # Email

_____

Father's Name Cell Phone # Home Phone # Work Phone # Email

_____

Other to call in Emergency:_____ Phone Number:_____

Medications Student Uses: _____ Medication used for: _____

Medication Allergies or Other Allergies_____

Physical Injury/Condition that should be watched:_____

Physician's Name: _____ Physician's Phone #:_____

Date of Physical Exam by Physician:_____

Name of Insurance Company:_____

Insurance Policy Number:_____(Mandatory)

PARENT CONSENT: I hereby give my consent for my son/daughter to compete in sports and accompany a school representative on any trips. In case of emergency, coaches or school personnel are authorized to have him/her treated.

_____

Date Parent/Guardian Signature

William S. Hart Union High School District

CERTIFICATE OF PHYSICAL EXAMINATION

Name_____DOB_____/____/____

Height_____Weight_____Pulse_____BP____/_____

Please place a "✔" as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments:_____

_____

List any restrictions and duration:_____

_____

I hereby certify that _____was examined by me on_____20_____and found to be physically fit to engage in athletics.

Physician's Signature_____**Date**_____

Stamp name or attach card of medical office here ▼

Medical History Form to be completed by parent/guardian before physical exam.

William S. Hart Union High School District

MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete_____

Sex_____Age_____DOB____/____/____

Grade_____School_____Sport(s)_____

Y or N (Circle Y or N. If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical? Y or N

_____

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication or using an inhaler? Y or N

_____

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects? Y or N

_____

4. Has the student-athlete ever had a seizure? Y or N

5. Has the student-athlete ever become ill from exercising in the heat? Y or N

6. Is there any pertinent medical information coaches or physicians should know about the student-athlete? Y or N

_____

7. Does the student-athlete wear glasses, contacts, or dental braces? Y or N

_____ _____

Parent/Guardian Signature **Date**

Henry Mayo
Newhall Hospital

AUTHORIZATION FOR SPORTS MEDICINE SERVICES AND CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of, _____, a minor and
Student-Athlete Name- Print

student-athlete at _____ who plans on participating in _____
Name of School Sport

I, hereby give consent for a certified Athletic Trainer, an employee of Henry Mayo Newhall Hospital, and/or other Henry Mayo Newhall Hospital clinical staff, who is contracted by the school to provide sports medicine services for the above minor. Sports medicine services include, but are not limited to: administrating first aid for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Athletic Trainer and/or sports medicine clinical staff will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. I understand that a written report of any athletic injury assessment will be confidentially maintained in the files of the training room or school nurse's office.

I, hereby authorize the Athletic Trainer and/or other Henry Mayo Newhall Hospital clinical staff who provide services to the above-named athlete to disclose information about the injury assessments and post injury status. This will be done as needed, with the coaching staff, Athletic Director of the school and if necessary; the school nurse, any treating healthcare provider and/or consulting concussion management specialist.

I understand that there is no charge to me for the above listed athletic training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice. Injured athletes that have seen a physician must submit written clearance from that physician to the Athletic Trainer prior to being permitted to resume activity. This authorization shall remain in effect for one sports season beginning with the date set forth below.

Parent/Guardian Name (print) _____ Signature _____ Date _____

Relationship to student-athlete _____ Cell/Work phone _____

Home Address _____ Home Phone _____

Student-Athlete Name (print) _____ Sex ___ Grade ____ Date of Birth _____

Allergies _____

Current Medications (i.e. asthma inhaler, epi-pen, etc) _____

Physical Impairments _____

Other pertinent medical history (surgeries, diabetes, seizures, heart condition, etc.) _____

_____

_____

Physician Name _____ Physician Phone _____