* **NEW**  **RENEWAL**  **UPDATE**

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| Age: | Grade Level: | Year: |
| Competitive Sport:  |  |  | School: |

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| **ATHLETE INFORMATION** |
| Last Name | First Name |
| Middle Name | Nickname |
| Date of Birth (MM/DD/YYYY) | Gender  Male  Female  | Eye Color |
| Address | City/State/Zip |
| Home Phone | Cell Phone |
| Email | I am my own guardian.  Yes  No |
| Employer | Employer’s City/State |
| Sports the athlete is interested in playing: |
| Emergency Contact *(if different from Parent/Guardian below)* |
| Cell Phone | Relationship to Athlete |

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| **PARENT/GUARDIAN INFORMATION** |
| Relationship to Athlete |
| Last Name | First Name |
| Home Phone | Cell Phone |
| Address | City/State/Zip |
| Email |
| Employer | Employer’s City/State |

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| **ATHLETE MEDICAL INFORMATION** |
| Primary Care Physician | Physician’s Phone |
| Physician’s Address | City/State/Zip |
| Health Insurance Provider |
| Has The Athlete Suffered the Following: *(check all that apply)*  Brocken Bones  Joint Dislocations  Sever Muscle Strains/ Sprains/ Pulls  Torn Ligaments  Concussions Explain Injury *(please specify)*: |
| The athlete uses *(check any that apply)** Dentures  Communication Device  Wheelchair  Brace  Removable Prosthetics  Splint
* Glasses or Contacts  Hearing Aid  Pacemaker  Inhaler  C-PAP Machine Other:
 |
| Athlete’s Allergies *(please list)*  No Known Allergies  Latex* Insect Bites or Stings:
* Food:
* Medications:
 |
| Does the athlete have any unusual body structures such as unequal pupils in the eye or other unusual bone structures caused by previous injury? Explain in Detail: |
| Does the athlete have any religious objections to medical treatment?  No  Yes *If yes, please complete the religious objections form.* |
| Does the athlete currently have any chronic or acute infection?  No  Yes *If yes, please describe:* |

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| **ATHLETE MEDICAL HISTORY** |
| PLEASE LIST ANY OF THE ATHLETE'S PHYSICAL CONDITIONS OR MEDICAL PROBLEMS WHICH YOU FEEL WOULD BE BENEFICIAL FOR THE ATHLETIC TRAINER, TEAM PHYSICIAN, OR HOSPITAL TO KNOW.  |
| List all past surgeries: |
| List all ongoing or past medical conditions: |
| List all medical conditions that run in the athlete’s family: |
| Has any relative died of a heart problem before age 40?  No  Yes | Has any relative died while exercising?  No  Yes |
| Has a doctor ever limited the athlete’s participation in sports?  No  Yes *If yes, please describe:* |
| Has the athlete ever had an abnormal Electrocardiogram (EKG)?  No  Yes *If yes, please describe:* |
| Has the athlete ever had an abnormal Echocardiogram (Echo)?  No  Yes *If yes, please describe:* |
| Has the athlete had a Tetanus vaccine within the past 7 years?  No  Yes |
| Any difficulty controlling bowels or bladder  No  Yes *If yes, is this new or worse in the past 3 years?* | * No
 | * Yes
 |
| Numbness or tingling in legs, arms, hands or feet  No  Yes *If yes, is this new or worse in the past 3 years?* | * No
 | * Yes
 |
| Weakness in legs, arms, hands or feet  No  Yes *If yes, is this new or worse in the past 3 years?* | * No
 | * Yes
 |
| Burner, stinger, pinched nerve or pain in the neck,  No  Yes *If yes, is this new or worse in the past 3 years?*back, shoulders, arms, hands, buttocks, legs or feet | * No
 | * Yes
 |
| Self-injurious behavior during the past year  No  Yes | Aggressive behavior during the past year | * No
 | * Yes
 |
| Depression  No  Yes | Anxiety | * No
 | * Yes
 |
| Please describe any additional mental health concerns: |

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| **MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS** *(includes inhalers, birth control or hormone therapy)* |
| **Name of Medication** | **Dosage** | **Times****per Day** | **Name of Medication** | **Dosage** | **Times****per Day** |
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| Is the athlete able to administer his/her own medications?  No  Yes |  |

**PLEASE READ BEFORE SIGNING**

**Participation:** I hereby give my permission for the participant named above to participate in Braxton County High School Athletics.

**Medical:** I represent and warrant to you that the athlete is physically and mentally able to participate in Local school and WVSSAC athletic Competition.

**Injury Disclaimer:** On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the BCS coaches, trainers, athletic director, district administration and Braxton County Board of Education from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or student athlete.

**Medical Care/ Hospitalization**.

PLEASE SIGN BELOW TO INDICATE THAT YOU GIVE THE BCHS ATHLETICS/ TRAINING DEPARTMENT, (ATHLETIC TRAINER, TEAM PHYSICIAN, COACH, ETC.) YOUR PERMISSION TO SEEK APPROPRIATE, IMMEDIATE MEDICAL ATTENTNTION FOR YOUR CHILD IF HE OR SHE IS Ill OR INJURED WHILE IN OUR CARE DURING PRACTICES, TRIPS, GAMES, ETC. IF IT IS DEEMED IMPOSSIBLE OR NOT FEASIBLE AT THE TIME OF INJURY TO REACH VOU.) OR YOUR FAMILY PHYSICIAN AND IF IT IS NOT FEASIBLE TO GO TO YOUR HOSPITAL FOR TREATMENT, WE HAVE YOUR PERMISSION TO SEEK THE NEAREST MEDICAL FACILITY FOR TREATMENT. ALSO, WE HAVE YOUR PERMISSION TO HAVE OUR TEAM PHYSICIAN CHECK YOUR SON OR YOUR DAUGHTER WHEN HE OR SHE IS PRESENT.

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| **ATHLETE OR PARENT/GUARDIAN SIGN AND DATE** |
| ***Athlete may sign if over the age of 18 and if you are your own guardian. Otherwise a parent or guardian must sign.*** |
| Printed Name | *Check One:*  Parent  Guardian  Athlete (over 18 & own guardian) |
| Signature | Date |