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2015-16 Medical Form

Health history (first three pages) must be completed by the parent/guardian of minors. Update of this information is required annually. The Health examination must be completed by an approved licensed medical authority.

Last Name	First Name	MI
Address		
City	State	Zip Code
Date of Birth	Gender	Grade

Insurance Information
Is the participant covered by family medical/hospital insurance? ❒ Yes ❒ No

If so, indicate carrier or plan name_____Group #_____

➔ Photocopy of front and back of health insurance card must be attached to this form.

This health history is correct and complete as far as I know. The person herein named has permission to engage in all sport team activities except as noted.

I hereby give permission to Five Points Runners Track Club, Inc. to provide, seek and consent to routine health care, administration of prescribed medications and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission to Five Points Runners Track Club, Inc. to arrange related transportation. I agree to the release of any records necessary for treatment, referral billing or insurance purposes.

It is my intention that Five Points Runners Track Club, Inc. be treated in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the Five Points Runners Track Club, Inc. be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability /Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to Five Points Runners Track Club, Inc. representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the Five Points Runners Track Club, Inc. representatives related to the person's ability to participate in athletic activities; and (ii) in the case of minors, to provide relevant information to the Five Points Runners Track Club, Inc. representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Five Points Runners Track Club, Inc. to secure and administer treatment, including hospitalization, for the person named above.

This completed form may be photocopied for trips/team athletic events.

Parent's or Guardian's Name (PRINT)_____

Parent's or Guardian's Signature _____Date:_____

Health History
The following information must be completed by the parent/guardian. The intent of this information is to provide the Team the relevant information to provide the appropriate care should it be required. Please keep a completed copy for your records. Any change should be reported to the Team immediately.

Allergies List all known — Describe reaction and management of reaction.

Medication allergies (list)

Food Allergies (list)

Other allergies (list)

Medications Being Taken
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

❒ This person takes NO medications on a routine basis.

❒ This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Restrictions
The following restrictions apply to this individual.

Dietary
Does not eat:

❒ red meat ❒ pork ❒ eggs ❒ poultry ❒ seafood ❒ dairy products ❒ gluten
❒ nuts ❒ other (describe) _____

General Questions (Explain "yes answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	❒	❒
2. Have a chronic or recurring illness/condition?	❒	❒
3. Ever been hospitalized?	❒	❒
4. Ever had surgery?	❒	❒
5. Have frequent headaches?	❒	❒
6. Ever had a head injury?	❒	❒
7. Ever been knocked unconscious?	❒	❒
8. Wear glasses, contacts or protective eye ware?	❒	❒
9. Ever had frequent ear infections?	❒	❒
10. Ever passed out during or after exercise?	❒	❒
11. Ever been dizzy during or after exercise?	❒	❒
12. Ever had seizures?	❒	❒
13. Ever had chest pain during or after exercise?	❒	❒
14. Ever had high blood pressure?	❒	❒

Has/does the participant:	Yes	No
15. Ever been diagnosed with a heart murmur?	❒	❒
16. Ever had back problems?	❒	❒
17. Ever had problems with joints (e.g., knees, ankles)?	❒	❒
18. Have any skin conditions (e.g., itching, rash, acne)?	❒	❒
19. Have diabetes?	❒	❒
20. Have asthma?	❒	❒
21. Had mononucleosis in the past 12 months?	❒	❒
22. Had problems with diarrhea/constipation?	❒	❒
23. If female, have an abnormal menstrual history?	❒	❒
24. Ever had an eating disorder?	❒	❒
25. Ever had emotional difficulties for which professional help was sought?	❒	❒

Please explain any "yes answers, noting the number of the question(s)

Which of the following has the participant had?

- ❒ Measles
- ❒ Chicken Pox
- ❒ German Measles
- ❒ Mumps
- ❒ Hepatitis A
- ❒ Hepatitis B
- ❒ Hepatitis C

TB Mantoux Test
Date of last test
Result: ❒ Positive ❒ Negative

Please provide all dates of immunizations for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	____	____	____	____	____	____
TD (tetanus/diptheria	____	____	____	____	____	____
Tetanus	____	____	____	____	____	____
Polio	____	____	____	____	____	____
MMR	____	____				
or Measles	____	____				
or Mumps	____	____				
or Rubella	____	____				
Haemophilus influenza B	____	____	____	____		
Hepatitis B	____	____	____			
Varicella (Chicken Pox)	____	____				

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the Team should be aware

Name of family physician	Phone
Address	

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on the following date: _____

BP _____ Weight _____ Height _____

In my opinion, the above individual ❒ is ❒ is not able to participate in active track and field programs.

The individual is under the care of a physician for the following conditions:

_____

_____

_____

_____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____