

# H. A. J. F. L.

## MEDICAL RELEASE FORM

I hereby give permission for any and all medical attention necessary to be administered to (child's name) \_\_\_\_\_ in the event of an accident, injury, sickness, etc., under the direction of the people listed below until such time as I may be contacted.

This release is effective for the time during which my child is participating in the HAJFL football program. I also hereby assume the responsibility for payment of any such treatment.

PARENT'S NAMES: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

PHYSICIAN'S PHONE NO.: \_\_\_\_\_

MY CHILD'S KNOWN ALLERGIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

In case I cannot be reached, either of the following people is designated:

COACH'S NAME: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

ASS'T COACH/OTHER: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

SIGNATURE PARENT/GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_

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HOME PHONE \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_ SEX \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

PARENT OR GUARDIAN'S NAME \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

CHECK SPORTS IN WHICH YOU PLAN TO PARTICIPATE:

___ BASEBALL	___ FOOTBALL	___ SKIING	___ TENNIS
___ BASKETBALL	___ GOLF	___ SOFTBALL	___ TRACK
___ CROSS COUNTRY	___ GYMNASTICS	___ SWIMMING	___ VOLLEYBALL
___ WRESTLING			

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_  
PARENT OR GUARDIAN

CIRCLE THE APPROPRIATE NUMBERS IF YOU HAVE HAD ANY OF THE FOLLOWING:

- |                                   |                         |   |
|-----------------------------------|-------------------------|---|
| 1. DRUG ALLERGIES<br>_____        | 11. HIGH BLOOD PRESSURE | 23. OPERATION ON TESTICLES                |
| 2. EYE INJURY OR DISEASE<br>_____ | 12. HEART SURGERY       | 24. KIDNEY TROUBLE                        |
| 3. EAR SURGERY                    | 13. CHRONIC COUGH       | 25. BROKEN BONES<br>_____                 |
| 4. MASTOID SURGERY                | 14. ASTHMA              | 26. BACK PROBLEM<br>_____                 |
| 5. FREQUENT SORE THROAT           | 15. COLLAPSED LUNG      | 27. SEVERE HEADACHES                      |
| 6. FAINTING OR DIZZY SPELLS       | 16. LUNG DISEASE        | 28. HEAD INJURIES                         |
| 7. CONVULSIONS                    | 17. HEPATITIS           | 29. NECK INJURIES                         |
| 8. RHEUMATIC FEVER                | 18. INFECTIOUS MONO     | 30. OTHER BONE OR JOINT<br>PROBLEMS _____ |
| 9. HEART DISEASE                  | 19. PEPTIC ULCER        |   |
| 10. DIABETES                      | 20. APPENDECTOMY        |   |
|                                   | 21. HERNIA              |   |
|                                   | 22. HERNIA REPAIR       |   |

WHAT MEDICATIONS DO YOU TAKE REGULARLY? \_\_\_\_\_

## PHYSICIAN TO COMPLETE THIS PORTION

PHYSICIANS COMMENTS ON CIRCLED ITEMS IN HISTORY SECTION ABOVE: \_\_\_\_\_

B.P. \_\_\_\_\_ PULSE \_\_\_\_\_ URINALYSIS: BLOOD \_\_\_\_\_ PROTEIN \_\_\_\_\_ SUGAR \_\_\_\_\_

CIRCLE NUMBER IF ABNORMAL AND EXPLAIN BELOW:

- |          |              |                  |                       |
|----------|--------------|------------------|-----------------------|
| 1. HEENT | 5. HEART     | 9. SKIN          | 13. UPPER EXTREMITIES |
| 2. TEETH | 6. ABDOMEN   | 10. PILONIDAL    | 14. LOWER EXTREMITIES |
| 3. CHEST | 7. HERNIA    | 11. LYMPH GLANDS |                       |
| 4. LUNG  | 8. GENITALIA | 12. BACK & NECK  |                       |

PHYSICIANS COMMENTS ON CIRCLED ITEMS: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_