

SUMTER CHRISTIAN SCHOOL STUDENT MEDICAL HISTORY

Name _____ Date _____

Address _____ Phone _____

Date of Birth _____ Height _____ Weight _____

INSURANCE INFORMATION:

Name of carrier _____ Name of Insured _____

Policy number _____ Social Security # _____

Phone number of insurance company _____

EMERGENCY CONTACT:

Name of person to contact in case of emergency:

Contact person _____ Relation to student _____

Address _____ Phone _____

PARENT INFORMATION:

Mother's name _____

Father's name _____

Address _____

Address _____

Phone: Cell _____

Phone: Cell _____

Work _____

Work _____

Home _____

Home _____

PARENTAL PERMISSION FOR ATHLETIC PARTICIPATION

To Sumter Christian School:

As the parent or legal guardian of _____, I give my consent for his/her participation in practice or games for any sport **circled** below and the medical evaluation required for that sport. To the best of my knowledge, my child has no other injuries or conditions which would affect his/her ability to participate in interscholastic athletics. I understand that injuries are a possibility and do not hold the school responsible in any way. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities. This includes any medical or surgical treatment thought necessary by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I also give my permission for my child to travel with the team by means of transportation provided by Sumter Christian School.

Soccer Volleyball Basketball Softball Baseball Cheerleading

Signed: _____

Date: _____

(Parent or legal guardian)

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?
(PLEASE CHECK “YES” OR “NO” AND EXPLAIN ANY “YES” ANSWERS.)

Yes	No	CONDITIONS	Explanation of condition or treatment
		Infectious mononucleosis	
		Virus pneumonia	
		Asthma	
		Rheumatic fever	
		Scarlet fever	
		High Blood Pressure	
		Heart murmur	
		Epileptic seizure	
		Hepatitis	
		Diabetes	
		Sickle cell anemia	
		Concussion	
		Knocked out	
		Head injury	
		Pinched nerve	
		Dislocations	
		Fractures	
		Heat stroke	
		Heat exhaustion	
		Shoulder/arm injury	
		Ankle sprains	
		Knee sprains	
		Cartilage or ligament damage	
		Back injury	
		Dental injury	
		Eye injury	
		Facial injury	
		Do you wear glasses?	
		Do you wear contacts?	
		Do you wear dental appliances?	
		Do you take prescribed medications or over the counter medications?	Name and dosage:
		Do you have any drug allergies?	
		Do you have any allergies to insects, food, or seasons?	
		Have you ever been told you had an enlarged or weak heart?	
		Have you ever had any surgeries? If so, give dates and descriptions.	