

Eugene School District 4J

Grade _____

ANNUAL INTERVAL HISTORY FORM

Student Name _____ School _____ Date of Birth _____

Parent/Guardian _____ Home Phone _____

Address _____ Zip _____

Sport(s) (List all that apply) _____

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PARENT/GUARDIAN PERMIT

I want my son/daughter to have the privilege of participating in competitive school athletics. (Name of student) _____ therefore, has my permission to complete in all sports approved by the Board of Education of the Eugene School District 4J and to be transported according to the District Transportation Policy.

While I expect school authorities to exercise reasonable precautions to avoid injury, I understand that there are risks of injury when participating in athletics and the District assumes no financial obligation for any injury that may occur. I am advised that students are held responsible for all players' equipment owned and issued by the school.

This consent to release a student athlete's health/medical information regarding an athletic injury, illness, or condition is vital for the Certified Athletic Trainer to perform his/her duties and expertise in treatment, rehabilitation, and return to play status of the student athlete through standing orders prescribed by the attending physician. I authorize Dr. _____ and Dr. _____ (if necessary) to communicate/release information with the Certified Athletic Trainer(s) and the student athlete's Coach about _____ (child's name) _____ (child's date of birth) and his/her medical/health condition as it relates to his/her ability to participate in sports and any written physician prescription of standing orders of treatment to be preformed by the Certified Athletic Trainer for the school calendar year. (Please indicate the school year 20__/20__)

Parent/Guardian Signature _____

Date _____

(over)

STUDENT ATHLETE MEDICAL INFORMATION

Past Medical Conditions (i.e. hospital, concussions, allergies, surgeries, fractures) _____

Present Medical Conditions (i.e. hospital, concussions, allergies, surgeries, fractures) _____

Medications/Supplements _____

Contact Lenses (please circle) Hard Soft None

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EMERGENCY CONTACT INFORMATION

Father/Guardian _____ Phone _____

Mother/Guardian _____ Phone _____

Preferred Hospital _____ Primary Care Physician _____

Person to contact if you cannot be reached _____

Relationship _____ Phone _____

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CONCENT TO TREAT/INSURANCE ARRANGEMENTS

In the event of a medical emergency to my son/daughter, I give consent for emergency medical treatment to be given to my son/daughter in the event that I/additional parent/guardian/emergency contact is not present for verbal consent for treatment. This consent extends to emergency medical personnel (i.e. EMT's Paramedics), physicians, nurses, certified athletic trainers, physical therapists, coaches, teachers, athletic directors, counselors, and principals that would be involved in the daily education, activities, and health of my son/daughter.

Please check one:

____ My son/daughter is covered by the student insurance plan as indicated for the 20__ /20__ school year.

 ____ 24 Hour ____ School-Time Plan ____ Student Health Care

 ____ Interscholastic Tackle Football Plan

____ My son/daughter is fully covered by insurance carried by Parent/Guardian, and the school will not be liable for any injury that occurs during athletic activities or travel for activities. (NOTE: If your insurance status changes, it is your responsibility to notify the Athletic Department. Lapses in coverage are NOT allowed.)

Name of company with which insured _____

Policy Number _____

Parent/Guardian Signature _____ Date _____