Argyle Student-Athlete Medical Form

Name of Student: _____ **Grade:** _____ **M/F:** _____

School: Argyle

Care Card Personal Health No. _____**Birth Date (DDMMYY):** _____

Family Doctor: _____ **Dr. Phone:** _____

Name of Parent/Guardian: _____

Address: _____ **Postal Code:** _____

Phone (Home) _____ **(Work)** _____ **(Cell)** _____

Please note any health condition, physical handicap, emotional difficulty, behaviour problem, or other factors that may limit full participation in this program:

_____

_____

Has the student had a previous injury that would require special first aid treatment should another injury occur?

_____

_____

_____

The student has received the regular immunization program administered in BC for: Diphtheria; Pertussis & Tetanus DPT; Tetanus and Diphtheria (TD); Polio; Measles, Mumps and Rubella (MMR) **Yes** **No** (circle)
If no, please explain _____

Does the student wear Contact Lenses: Yes No (circle)

Student is subject to:

( ) asthma	( ) eye infections	( ) motion sickness	( ) sinus problems
( ) bronchitis	( ) fainting	( ) muscle pulls	( ) sleep walking
( ) dislocations	( ) frequent colds	( ) nose bleeds	( ) sprains
( ) dizziness	( ) headaches	( ) seizures	( ) tonsillitis
( ) ear aches	( ) high blood pressure	( ) sensitive skin	
	( ) kidney problems	( ) severe allergies/anaphylaxis (*provide detail below)	

( ) Other conditions and/or *further detail (describe below or attach separate sheet)

Alternate Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.

Parent/Guardian Signature _____ Date: _____

THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND ON FILE