

**PHYSICAL EXAMINATION MUST OCCUR AFTER JULY 1
TO BE VALID FOR THE UPCOMING SCHOOL YEAR**

AUBURN SCHOOL DISTRICT ATHLETIC REGISTRATION

HEALTH HISTORY

(To be completed by parent or guardian)

Does your student have any special health problems (diabetes, allergies, spells, seizures, bleeder, heart problems, etc.) or has he or she had an operation or been hospitalized? _____

Is there anything you can tell us about your student that you feel will help us to better understand and work with her or him? _____

Does your student take medications regularly? ____ Yes ____ No Type: _____

Does your child wear glasses? ____ Yes ____ No Contact Lenses? ____ Yes ____ No

Doctor's Name _____ Telephone _____

CONSENT TO MEDICAL CARE AND TREATMENT--EMERGENCY INFORMATION

I, _____ authorize all medical, surgical, diagnostic, and hospital
(Parent or Legal Guardian)

procedures as may be performed or prescribed by a treating physician for _____
(Student's Name)

if I cannot be reached in the case of any emergency.

(Signature of parent/guardian)

(Date)

MEDICAL EVALUATION REPORT

(To be completed by physician only)

I have examined _____ on _____. In my opinion, the named
(Name) (Date)
student is able to participate in the physical education and/or athletic program. ____ Yes ____ No

Physical Limitations: _____

Specific Recommendations: _____

If _____ competes in wrestling, the minimum weight should be no less than ____ pounds.
(Name)

Doctor's Signature _____ Doctor's Name _____

Address _____ Telephone _____

