**TO BE COMPLETED BY PARENT:**

Player Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Past Medical History: | Yes | No |  | Review of Systems: Please check if there are any problems with any of the following areas of your body: | |
| 1. Presently taking medication |  |  |  | \_\_\_\_Skin | \_\_\_\_Abdomen |
| 2. Allergic to medicine, food, etc. |  |  |  |  |  |
| 3. Wears glasses, contact lenses, hearing aid, dentures |  |  |  | \_\_\_\_Head | \_\_\_\_Back |
| 4. History of braces, chipped teeth, bridges |  |  |  | \_\_\_\_Eyes | \_\_\_\_Bowel/Bladder |
| 5. Has ongoing medical problem |  |  |  | \_\_\_\_Ears | \_\_\_\_Genital |
| 6. Had serious or significant illness in the past |  |  |  | \_\_\_\_Nose | \_\_\_\_Shoulders, arms, hands |
| 7. Any past surgical procedures |  |  |  |  |  |
| 8. History of concussion |  |  |  | \_\_\_\_Mouth/throat | \_\_\_\_Hips, legs, feet |
| 9. Any past injuries/accidents requiring medical help |  |  |  | \_\_\_\_Neck | \_\_\_\_Muscle strength, feeling |
| 10. Any past injuries directly related to sports |  |  |  | \_\_\_\_Lungs | \_\_\_\_Mental problems |
| 11. Any hospitalization not explained above |  |  |  | \_\_\_\_Heart |  |
| 12. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.) |  |  |  |  |  |
| 13. Any serious family illness (such as diabetes, bleeding disorders, heart attack before age 50, etc.) |  |  |  | \*Date of last Tetanus shot:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

If yes to any of the above, please explain (what/where/when):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I certify that the above information is correct to the best of my knowledge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature

Height\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visual Acuity: (R) 20/\_\_\_\_\_ (L) 20/\_\_\_\_\_ without glasses\_\_\_\_ with glasses\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Normal | Abnormal findings |  | Normal | Abnormal findings |
| 1. General | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 5. Heart | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. HEENT-neck | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 6. Abdomen | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. Skin | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 7. Genitalia/hernia | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Lungs | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 8. Orthopedic | \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Recommendations/comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physicians Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician and Parents - Please complete Red Rose Contract on reverse side**