Alaska School Activities Association

HEALTH EXAMINATION FORM

MEDICAL HISTORY TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Last Name (Print)	First Name (Print)	Initial	Date of Birth

Have you or any members of your family under age 50 had a "heart attack" or sudden death?	*Y*____	*N*____
Have you ever had any chest pain or passed out while exercising?	*Y*____	*N*____
Do you cough or have trouble breathing during or after exercise?	*Y*____	*N*____
Have you ever had an illness or injury that required hospitalization?	*Y*____	*N*____
Have you ever made repeated visits to a doctor for an illness or injury?	*Y*____	*N*____
Do you have any allergies?	*Y*____	*N*____
Are you presently taking any medications?	*Y*____	*N*____
In the past year, have you had a significant illness or injury?	*Y*____	*N*____

*Explain any yes answers:*_____

I hereby consent to the information on the reverse side of this form

Student signature	*Parent signature*	*Date*

HEALTH EXAMINATION TO BE COMPLETED BY PHYSICIAN

AGE	HEIGHT	WEIGHT	BLOOD PRESSURE	VISION R/20	VISION L/20

Circle any of the following that are abnormal and explain under Comments:

Eyes/Ears/Nose/Throat Genitilia, Tanner Stage ____ Knee/Hip PERRLA Neurological
Back Respiratory Skin Ankles Cardiovascular Head/Neck Other Musculoskeletal
Liver/Spleen/Abdomen LAB: UA, HGB/HCT (as needed) DT (Date): _____

Comments:_____

I certify that on this date, I have examined this student and find him/her physically able to compete in all supervised activities not crossed out: Wrestling, Football, Gymnastics, Swimming, Diving, Soccer, Cheerleading, Riflery, Weight Training, Ice Hockey, Track and Field, Volleyball, Basketball, Tennis, Cross Country Skiing, Cross Country Running, Baseball, Softball

PHYSICIAN'S NAME (PRINTED)	*Examining Physician's Signature*	*Date of Examination*

Physician's Address

City State

Phone number Zip Code

The physician's stamp is required in this space

Please make three (3) copies for the School, Student/Parent, and Examining Physician

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HEALTH EXAMINATION
CONSENT INFORMATION

I hereby consent to emergency treatment, hospitalization, or other medical treatment as may be necessary by a physician, qualified nurse, or hospital in the event of an injury or illness.

I hereby consent to participation in ASAA approved interscholastic activities.

I hereby consent to travel to and from ASAA activities via school approved transportation.

I hereby waive on behalf of myself and the above student any liability of the school or ASAA organizationally or for any of its officers, agents, or employees for injuries sustained in the interscholastic program.

I accept financial responsibility of the above student in the event of an injury or illness.

I accept legal responsibility of the above student in the event of an injury or illness.

I hereby state that information submitted on this form is true.

I hereby consent to abiding by the ASAA rules and regulations and school handbook.