LAKEHEAD ELEMENTARY INTERSCHOOL ATHLETIC PARTICIPATION FORM

This form is to be completed on behalf of a student who wishes to participate in interschool sport and returned to the coach prior to the student's first practice.

STUDENTS NAME _____ SCHOOL_____
ADDRESS _____ POSTAL CODE _____
PHONE # _____ HEALTH CARD NO. _____
PARENT/GUARDIAN _____ WORK PHONE # _____
STUDENTS PHYSICIAN _____ PHONE # _____
EMERGENCY CONTACT NAME _____ PHONE # _____

NOTE TO PARENT/GUARDIAN: **An annual medical examination is recommended**

MEDICAL INFORMATION

1. Date of last complete examination _____
2. Date of last tetanus immunization _____
3. Is your son/daughter/ward allergic to any drugs, food or medication/other? Yes _____No _____If yes, provide details _____
4. Does your son/daughter/ward take any prescriptions drugs? Yes _____ No _____ If yes provide details _____
5. What medication(s) should the participant have on hand during the sport activity? _____
6. Does your son/daughter/ward wear a medical alert bracelet _____, neck chain _____ or carry a medical alert card? Yes__No ___
7. Does your son/daughter ward wear eyeglasses? Yes _____ No _____ Contact lenses? Yes _____ No _____
8. Please indicate if your son/daughter/ward has been subject to any of the following and provide pertinent details:
   epilepsy, diabetes, orthopedic problems, deaf. hard hearing. asthma, allergies _____
   head or back conditions or injuries (in the past two years) _____
   arthritis or rheumatism, chronic nosebleeds; dizziness; fainting; headaches; hernia; swollen, hyper mobile or painful joints; trick or lock knee___
   _____
   Any other medical information that will limit participation? _____
9. Should your son/daughter/ward sustain an injury or contact an illness requiring medical attention during the competitive season, notify the coach and complete the "Request to Resume Athletic Participation Form", if applicable.

10. MEDICAL SERVICES AUTHORIZATION (optional)

In case of emergency medical or hospital services being required by the above listed participation, and with the understanding that every reasonable effort will be made by the school/hospital to contact me, my signature on this form authorizes medical personal and /or hospital to administer medical and/or surgical services including anesthesia and drugs. I understand that any cost will be my responsibility.

SIGNATURE OF PARENT/ GUARDIAN _____ DATE_____