ATHLETE PHYSICAL AND RELEASE FORMS (PLEASE PRINT)

Athlete Name____ Nick Name______________________ Male_________ Female___________

Social Security Number__________-_______-__________ County_________________________

Address____ Birthday________________________

City____State___________Zip__________________ Home Phone_____________________

Parent/Guardian Name____

Address (if different than athlete)____ Work Phone_____________________

City____State_________Zip__________________ Home Phone_____________________

Emergency Contact (if other than parent/guardian)_____________________________________ Home Phone_____________________

Parent Guardian Employer____

Health Insurance Company____
Policy #_________________________

Person Completing Form______________________________________Date__________________ Relationship to Athlete___________________

Signature

	YES	NO
1. Diabetes		
2. Seizures/ Epilepsy		
3. Heart Disease/Heart Defect/High Blood Pressure		
4. Chest Pain or Fainting Spells		
5. Parent/Sibling (under 40) with heart disease		
6. Down Syndrome		
Has cervical spine x-ray been completed for Atlanto-axial Instability?		
X-ray results: ________positive		
________negative		
7. Absence of Vision/blind one or both eyes		
8. Absence of one kidney or testicle		
9. Major surgery or serious illness		
10. Heat stroke/exhaustion		
11. Concussion or serious head injury		
12. Other problems that would interfere w/sports		
List____________________________________		
____		
____		
13. Dentures/False Teeth		
14. Contact Lenses/eyeglasses		
15. Hearing loss/hearing aid		
16. Sickle cell trait or disease		
17. Serious bone or joint disorder		
18. Emotional/psychiatric/behavioral problems		
19. Tendency to bleed easily		
20. Exercise induced wheezing		
21. Respiratory problems		
22. Uses Assistive device		
List_________________________________		
23. Impaired motor ability		
24. Special diet		

MEDICATIONS:
____
____
____
____
____
____

COMMENTS:
____
____
____

ALLERGIES:
Food__________________________________
____
Medications____________________________
____
____
Insects stings/bites_______________________
____
____

Blood Pressure_____________________________
Height__________ Respiration____________
Weight__________ Pulse________________
Date of last Tetanus shot_____________________
Immunizations up-to-date____________________

To be filled out by a Licensed Examiner:
If history was completed by an adult athlete - I have reviewed the health history with the athlete whose signature appears above.

Examiner's Note: If the athlete has Down Syndrome, Champion Athletes of the Ozarks requires a full radiological examination establishing the absence of Atlanto-axial Instability before he or she may participate in sports or events which by nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events that a radiological examination is required are: horse back riding, gymnastics, pentathlon, butterfly stroke, diving starts, high jump and soccer.

I have reviewed the above health information and examined the athlete named above, and certify there is no medical evidence available to me which would preclude the athlete's participation in Champion Athletes of the Ozarks.

RESTRICTIONS____

EXAMINER'S SIGNATURE____ DATE_________________________________

EXAMINER'S NAME____

ADDRESS____ PHONE_________________________________

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