

**Central Kitsap School District**  
**Medical History and Waiver - Emergency Reference**

Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) (M/F) DOB: \_\_\_\_\_ Year: \_\_\_\_\_ (7,8,9,10,11,12) Sport: \_\_\_\_\_

Address: \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_ (Parent/Guardian Home Telephone)

Parent/Guardian Name \_\_\_\_\_ Work # \_\_\_\_\_ Cellular #: \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work # \_\_\_\_\_ Cellular #: \_\_\_\_\_

Emergency contact #1: \_\_\_\_\_ Telephone (H/W): \_\_\_\_\_

Emergency contact #2: \_\_\_\_\_ Telephone (H/W): \_\_\_\_\_

Athlete's physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

**Please circle "Yes" or "No". Please provide additional details to any questions answered "Yes" in 1-11 below.**

1. Yes/No Has any medical condition, which may affect athletic participation? \_\_\_\_\_  
What? \_\_\_\_\_

2. Yes/No Has had injuries/illness lasting more than one week in the last year? \_\_\_\_\_  
What? \_\_\_\_\_

3. Yes/No Has any food, pollen or drug allergy? \_\_\_\_\_ Which? \_\_\_\_\_  
Describe the severity of reaction: \_\_\_\_\_

4. Yes/No Is presently taking medication of any kind? \_\_\_\_\_  
What? \_\_\_\_\_ Is self-medicated? \_\_\_\_\_

5. Yes/No Is presently under a physician's care? \_\_\_\_\_ Why? \_\_\_\_\_  
Physician's name: \_\_\_\_\_ Released to participate date: \_\_\_\_\_

6. Yes/ No Has high blood pressure? \_\_\_\_\_ Heart disease? \_\_\_\_\_ Organ abnormalities? \_\_\_\_\_

7. Yes/No Has a history of a concussion, seizure, epilepsy or headaches? \_\_\_\_\_

8. Yes/No Has been medically diagnosed with heat exhaustion/stroke? \_\_\_\_\_

9. Yes/No Has been professionally diagnosed with exercise induced asthma? \_\_\_\_\_  
Describe the severity of reaction: \_\_\_\_\_

10. Yes/No Has been hospitalized for injury or illness? \_\_\_\_\_  
What? \_\_\_\_\_ When? \_\_\_\_\_

11. Yes/No Has had any injury or illness requiring medical attention in the past three years? \_\_\_\_\_  
What? \_\_\_\_\_ When? \_\_\_\_\_

12. Yes/No Has been immunized for Tetanus? \_\_\_\_\_ When? \_\_\_\_\_

Please provide additional details in this space to any questions answered "Yes" in 1-11.

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The information provided above is accurate. In the event of injury or illness, the athlete stated above may be transported to a medical facility for care. As the legal authority of the above person, I hereby give my permission to medical personnel to provide treatment as needed. I understand and agree that medical information may be shared with other healthcare professionals.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_