EMN Athlete Medical Form

Medical Form/Certificate of Immunization

You may substitute this entire document with the standard form provided by the physician's office

Name: _____ Date of Birth: _____

HEALTH HISTORY: (Circle any that apply)

Heart Problems	Hay Fever	Earaches	German Measles	Asthma
Sinus Problems	Whooping Cough	Measles	Chickenpox	
Bee Sting Allergy	Diabetes	Mumps	**Drug Allergy**	Seizures
Ivy, Oak Allergies	Glasses	Contacts	**Food Allergy (specify)**	

Detail any of the above: _____

_____

_____

_____

_____

Medication being taken (name and explain): _____

_____

_____

Operations, injuries, special restrictions (give dates): _____

_____

_____

HEALTH EXAMINATION:

Date of last physical examination by licensed physician: _____

(*must be within 13 months preceding your child's participation in EMN programs)*

RECORD OF IMMUNIZATIONS: List month and year

DTaP/DTP/DT (4 doses)	_____	_____	_____	_____
Polio (3 doses)		_____	_____	_____
Hepatitis B (3 doses)		_____	_____	_____
M.M.R. (2 doses)			_____	_____
Td booster (1 dose while in Grades 7-12)				_____

I certify that the above medical information is complete and accurate, and the above named program participant may fully participate in the program.

Physician Signature: _____ Date: _____

Print Name: _____

Address: _____Phone: _____

Parent Signature: _____ Date: _____

(*Parent signature certifies that no significant health problems have occurred since date of exam.*)