

EMN/CSU 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/CSU 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.)