

## Lewiston School District Athletic Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F Grade: \_\_\_\_\_

Participating Sports: \_\_\_\_\_

Parent Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone :(\_\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_

If parent/guardian in unavailable, please call:

Name: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_ OR (\_\_\_\_\_) \_\_\_\_\_

**School health insurance needed: \_\_\_Yes \_\_\_No**

If yes, a premium charge will be required prior to participation in any IHSAA athletic activity. More information may be obtained from Lewiston High School, Jenifer Junior High or Sacajawea Junior High. **Athletes must be covered under a healthcare insurance policy.**

Insurance Co: \_\_\_\_\_ Policy number: \_\_\_\_\_

### PHYSICAL INFORMATION

Have you had an injury in the past year to:

_____ HEAD	_____ WRIST	_____ HAMSTING	_____ ANKLE
_____ NECK	_____ HAND	_____ QUADRICEPS	_____ FOOT
_____ SHOULDER	_____ BACK	_____ KNEE	
_____ ELBOW	_____ HIP	_____ LOWER LEG	

Check any of the following past or present conditions that apply:

_____ DIABETES	_____ HEART MURMUR	_____ INTERNAL ORGAN INJURY
_____ ASTHMA	_____ ALLERGIES	_____ BLEEDING DISORDER
_____ HEPATITIS	_____ HIGH BLOOD PRESSURE	_____ SERIOUS NECK INJURY

If you answered yes to any of the above, please explain: \_\_\_\_\_

**If you have ever had a head injury, complete the following questions:**

Were you seen by a physician? Yes / No Were you hospitalized? Yes / No

How many concussions have you had within the last 5 years? \_\_\_\_\_

On what date(s)? \_\_\_\_\_

Are you currently taking any prescription or over the counter medications? If yes, please list: \_\_\_\_\_

Please list any surgeries or health conditions not listed above in the past five (5) years: \_\_\_\_\_

## **MEDICAL HISTORY WAIVER/AUTHORIZATION TO TREAT CONSENT FOR PARTICIPATION AND RELEASE OF LIABILITY**

**Physical information:** (to be completed by parent/guardian and student)

The state of Idaho requires complete physicals for athletic participation during grades 7, 9, and 11.

My son/daughter had a complete physical examination on (date): \_\_\_\_\_

I give permission to have a baseline/post-concussion IMPACT test administered at Lewiston High School, Jenifer Junior High or Sacajawea Junior High. I understand that my child may need to be tested more than once when being evaluated for a concussion. This test will be compared to baseline scores.

I (parent/guardian) give authorization to the athletic training staff and or medical consultants to evaluate, treat, and render first aid to injuries that occur to my son/daughter while participating in Lewiston School District Athletics.

**Academic Information:** (to be completed by the student)

**I (student) have read and understand that I am obligated to adhere to the policies set forth in the HANDBOOK FOR STUDENT ATHLETES during those sport seasons in which I am a participant.**

If you are a transfer student, please give the name and dates of the last school attended: \_\_\_\_\_

**My participation in interscholastic athletics for the Lewiston School District is entirely voluntary on my part, and with the understanding that I have not violated any of the eligibility rules and regulations of the state association.**

**Parent consent:**

I/We understand that in the best programs, sports have the potential for injury, even disability or death can occur on rare occasions. I/We release the Lewiston School District and staff from liabilities and claims from injuries that may occur during a practice or event.

I/We give my/our consent for \_\_\_\_\_ to participate in Lewiston School District Athletic programs, including travel to and from contest and practices.

I/We release the Lewiston School District and staff from liabilities arising out of an injury or damages while traveling to and from practices and events.

I/We have completed the athletic medical history questionnaire to the best of my knowledge. I also affirm that my student athlete does not suffer from any disability, injury, condition, complaint, or problem that we have not disclosed on this questionnaire.

**I/We (parent/athlete) also give our consent to release any information contained in this form to carry out treatment and healthcare operations for student named below.**

PARENT/GUARDIAN NAME (PRINTED): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

STUDENT NAME (PRINTED): \_\_\_\_\_

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_