

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: _____