HEALTH REPORT

CONTACT INFO

Player Name _____ Grade _____ Birthdate _____
Home Address _____ City _____ State _____ Zip _____
Father's Name _____ Cell # _____
Mother's Name _____ Cell # _____

LOCAL EMERGENCY NUMBERS (to be called if parent/guardian cannot be reached)

Name _____ Relationship _____ Cell # _____
Primary Physician _____ Phone _____
Dentist _____ Phone _____
Is the athlete under physician's care at this time? YES NO **If so, explain** _____
Does athlete have allergies? YES NO **If yes, please circle type**: FOOD INHALANTS ASTHMA HAY FEVER Does athlete take any medication for above allergies? YES NO Name of Medication _____ Does athlete have a physical handicap? YES NO **If yes, is it (CIRCLE)** CONGENITAL or ACQUIRED Please explain

_____

Does athlete have a history of any of the following:

YES NO Diabetes **If yes, initial diagnosis** (date) _____ Under control? YES NO Medication? _____ YES NO Hypoglycemia (low blood sugar)
YES NO Sickle Cell Anemia
YES NO Throat Infections (chronic or strep)
YES NO Convulsive disorders (seizures) **(CIRCLE)** GRAND MAL PETIT MAL OTHER Medication? _____ YES NO Fever convulsions (date of last episode) _____

Does athlete have a history of any of the following:

YES NO Hyperventilation
YES NO Fainting (explain) _____
YES NO Head injuries or major accidents of any kind? (explain) _____
YES NO Heart, cardiovascular disease or high blood pressure? (explain) _____
YES NO Hyperactivity (explain) _____
YES NO Emotional problems (explain) _____
YES NO Vision – Glasses **(CIRCLE)** FULL-TIME or PART-TIME Contact lenses **(CIRCLE)** FULL-TIME or PART-TIME YES NO Eye surgery? (explain) _____

Last tetanus immunization

_____

Health concerns not mentioned; include hospitalization or operation _____

In case of emergency, at which hospital do you want your child treated? _____
I hereby authorize the physician in charge of (player's name) _____ to administer any treatment or to administer such anesthetics, perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I accept the treatment deemed necessary by the physician treating the emergency; if time allows, I prefer that (physician's name) _____ treat my child.

_____	_____	_____
Signature of Parent / Guardian	**Printed Name of Parent / Guardian**	**Date Signed**

Medical Authorization

I/we hereby authorize the coaching staff of the Kansas City Premiere Basketball Program to act according to their best judgment in any situation requiring medical attention, whether an emergency or not, until such time as I/we can be contacted to make decisions regarding the treatment of (player's name) _____.

_____	_____	_____
Signature of Parent / Guardian	**Printed Name of Parent / Guardian**	**Date Signed**