SCHOOL YEAR:
_____

LIMESTONE COUNTY SCHOOLS

Athletic Health Information Form

Student's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth: _____ Grade:_____

Parent/Guardian Contact: _____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone Number:_____

Cell Phone Number:_____

Work Number:_____

Medical Insurance Information:

Provider:_____

Contract Number: _____

Group Number:_____

Parent/Guardian Contact: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____

Cell Phone Number:_____

Work Number:_____

Does Student Have:

Allergies	Yes	No	If yes,	Specify:_____
Asthma	Yes	No	If yes,	Location of his/her inhaler:_____
Diabetes	Yes	No	If yes,	Insulin specifications: _____
Epilepsy or Seizures	Yes	No	If yes,	Specify:_____
Heart Conditions	Yes	No	If yes,	Specify:_____
Trouble Seeing	Yes	No	If yes,	(Circle one), Glasses Contacts Both None
Trouble Hearing	Yes	No	If yes,	(Circle one), Hearing Aide None
Other Known Health Problems	Yes	No	If yes,	Specify:_____
Up to date Tetanus Shot	Yes	No	If yes,	Date of last Tetanus Shot:_____
Does Student Take Medication	Yes	No	If yes,	Type:_____ Rate:_____ Dosage:_____
				Type:_____ Rate:_____ Dosage:_____
				Type:_____ Rate:_____ Dosage:_____

Note: No Trainer or Coach will administer any medication. The school nurse with written permission from you is the only school employee designated to do so.

Please circle *all* sports of participation during the ***Athletic Season*:**

Boys - Football
Girls - Volleyball
Cross Country
Cross Country
Basketball
Basketball
Baseball
Softball
Soccer
Soccer
Golf
Cheer

Physician Information:

Student's Physician:_____

Physician's Address:_____

City:_____ State:_____ Zip:_____

Physician's Phone Number:_____

Emergency Number:

If unable to reach parent/guardian, please contact:

Name:_____

Relationship to Student:_____

Home Number:_____ Cell:_____

Signature of Student:_____

Signature of Parent/Guardian:_____