# CHARLOTTE HIGH SCHOOL
# ATHLETIC DEPARTMENT MEDICAL HISTORY QUESTIONAIRE AND ATHLETIC TRAINER CONSENT FORM

NAME_____PHONE#_____

DATE OF BIRTH_____GRADE NOW_____GRAD YEAR_____

Have you ever been informed by a physician that you have any of the following: (circle all that apply) Asthma, Diabetes, Epilepsy, High Blood Pressure, Hemophilia

List **ALL** medications that you are taking at this time:

_____

_____

_____

List all surgeries that you've had in the last two years:

_____

_____

_____

Have you ever had a concussion or been knocked out? YES NO
When?_____

Please list any other medical problems that you may have, and any medications that you may be taking:

_____

_____

_____

In case of injury or emergency, I give my consent to emergency or other medical treatment necessary by the athletic trainer contracted by Charlotte Public Schools. Such treatment may include but shall not be limited to:

1. Initial evaluation and consultation of the injured athlete.
2. Emergency first aid.
3. Ongoing rehabilitation of the injured athlete.
4. Application/fabrication of protective braces/splints for support of the injured athlete.
5. Appropriate return to sport of the injured athlete.

_____ _____

Parent/Guardian Signature Date