LINCOLN PUBLIC SCHOOL
AUTHORIZATION FOR MEDICAL SERVICES

THIS INFORMATION WILL ACCOMPANY YOUR STUDENT WHEN EMERGENCY ROOM ADMISSION IS APPROPRIATE AND PARENTS/GUARDIANS ARE NOT AVAILABLE

THIS FORM MUST BE COMPLETED FOR EXTRACURRICULAR ACTIVITY AND SUBMITTED TO THE SCHOOL NURSE PRIOR TO THE START OF EACH SEASON A STUDENT PLANS TO PRACTICE, COMPETE, PERFORM AND/OR PARTICIPATE IN ANY EXTRACURRICULAR ACTIVITY.

Student's Name: ____Date of Birth: ___________________Sex:_________

Address: ____ Grade:_________ Home Phone: _____________________

Parent Name: ____ Parent Name: ____

Work Phone: ____Work Phone: ____

Cell Phone: ____ Cell Phone: ____

Significant current or past medical problems or injuries:

Allergy to medication or other allergies:

Medications currently taking: (list)

Emergency Medications Required: _____ EPI-PEN _____ INHALER _____ INSULIN _____ DIASTAT _____OTHER
NOTE: Students with current asthma or allergy problems will not be allowed to participate without their <u>prescribed</u> medications in their immediate possession. This includes, but is not limited to: Epi-pens, inhalers, nebulizers, and peak flow meters.

Please Check One: _________My child does not need any emergency medication.

_________My child will have his/her emergency medication in his/her possession during after-school activities.

Date of last tetanus immunization: _____________________

Physician's Name: ____ Phone Number: _______________________

Health Insurance Company: ________________________________ ID No. ______________________Group No. ______________

I authorize the activity leader/coach of the Hanscom Public Schools to obtain emergency medical care for my child for illness or injury received during participation in extracurricular activities including travel. Permission is also given to the attending physician to treat said illness or injury. The Coach/Teacher will make every reasonable attempt to contact parents/guardians in the event of emergency illness or injury. The Coach/Teacher will carry this signed form in insure proper care and treatment of my child.

Parent's/Guardian's Signature: **Date**

OTHER SIDE OF FORM MUST BE COMPLETED FOR PARTICIPATION IN ANY SPORT.

Pre-Participation Head Injury/Concussion
Reporting Form

If yes is checked, please explain. (Use extra sheet if necessary)

		YES	NO
1.	Has student ever experienced a traumatic head injury (blow to the head)? • If yes, when? Dates (month/year)		
2.	Has student ever received medical attention for a head injury? • If yes, when? Dates (month/year) _______________ • If yes, please describe the circumstances		
3.	Has student ever received a face or cervical spine injury? If yes, when? Dates (month/year)		
4.	Was student diagnosed with a concussion? • If yes, when? Dates (month/year) _______________ • Durations of symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion		

Additional Medical History
If yes is checked, please explain. (Use extra sheet if necessary)

		Yes	No
1	Has a physician ever denied or restricted student's participation in sports for any problems?		
2	Has student ever been dizzy or passed out during or after exercise?		
3	Has student ever had a heart murmur, irregular rhythm, or high blood pressure?		
4	Has student ever had chest pain during or after exercise?		
5	Has student ever had seizures?		
6	Has student ever dislocated a bone? If yes, which one & when?		
7	Has student ever had surgery? If yes, for what & when?		

I hereby state that I have reviewed this medical history and find the answers to these questions correct to the best of my knowledge (Required for legal minors)

____ _______________

Parent(s)/Guardian(s) Signature Date

____ _______________

Student Athlete Signature Date