MEDICAL CONSENT FORM for JUNIATA CHRISTIAN SCHOOL
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Student Name: _____ Grade: _____

This is to authorize, empower, and direct you to treat the above named person to such an extent as you shall deem reasonably necessary under the circumstances as they appear to you. We, the parent(s) or guardian(s), consent to such treatment and severally obligate ourselves to pay the reasonable charges thereafter.

Permission is also granted to the athletic trainer to provide the needed emergency treatment to the athlete prior to his admission to the medical facilities.

The word "treat" shall include any and all medical, surgical, osteopathic, nursing, diagnostic, and any other procedures including major and minor surgery generally accepted by the medical or osteopathic profession.

I understand that every attempt will be made by the attending physician or hospital to contact me in the most expeditious way possible. If said physician or hospital is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

To the best of my knowledge, the following information is correct:

Medical Insurance _____ Policy No. _____

Religion _____ Family Doctor _____ Blood Type _____

Known Allergies _____

List any medication student is presently on _____

Home Phone _____ Work Phone _____ Cell Phone _____

Signature of Parent / Guardian _____ Date _____

Parent: Please check any of the following medical problems listed below:

_____ Polio	_____Mononucleosis	_____ Diabetes	_____ Breathing Problems	_____ T.B.
_____ Vision	_____Broken Bones	_____ Allergies	_____ Operations	_____ Hernia
_____ Kidney	_____Heart Disease	_____ Emotional	_____ Epilepsy	_____ Other
_____ Hearing	_____Rheumatic Fever			

If any of the above medical problems have been checked, please explain. (List all supportive devices, necessary medication, etc.) Please be specific.

_____

_____

Please list the date of your child's last tetanus booster shot: _____

Please list any additional comments that you as a parent or guardian feel would be beneficial for the Juniata Christian Athletic Department to be aware of: _____

Person to notify in our absence _____ Phone _____ Cell _____

Signature of Parent / Guardian _____ Date _____

ATHLETIC PHYSICAL FORM
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To be completed by the parent/student before examination	
Student Name:	
Date of Birth:	Place of Birth:
Circle Grade: 5 6 7 8 9 10 11 12	School: Juniata Christian School

PHYSICAL EXAMINATION SUMMARY

To be completed by the examining MD, DO, PA or NP & Returned directly to the patient.					
EXAMINATION: Height: Weight: Male/Female BP: / Pulse:					
MEDICAL	NORMAL	ABNORMAL FINDINGS	MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Eyes/Ears/Nose/Throat:			Neck:		
Lymph Nodes			Back:		
Heart: Murmurs			Shoulder/Arm		
Lungs:			Elbow/Forearm		
Abdomen:			Wrist/Hand/Fingers		
Skin:			Hip/Thigh		
Neurologic:			Knee		
			Leg/Ankle		
			Foot/Toes		

Is there evidence of hernia? _____ yes _____ no

If yes, would athletic competition be likely to be injurious? _____ yes _____ no

Signature of examining physician _____

Printed name of examining physician _____

Date _____

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