Riverhead CSD
School Physical Consent Form

Student Name:_____ DOB:____/_____/_____

Student ID:_____ Grade:_____

Has your child ever had any of the following?

Medical / Surgical History	NO	YES	Date	If yes, please explain
Have an ongoing medical condition? Check below: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle Cell Trait of Disease ☐ Other				
Ever had surgery?				
Ever spent the night in a hospital?				
Have a life threatening allergy? Check below: ☐ Medication ☐ Food ☐ Insect Bites ☐ Pollen ☐ Latex ☐ Other				
Carry an epinephrine auto-injector?				
Ever passed out during or after exercise?				
Ever been told they have a heart condition or problem?				
Ever been told by their health care provider they have asthma?				
Use or carry an inhaler or nebulizer?				
Had injury or illness in the last 6 months, which lasted more than 5 days?				
Ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told she/he had a concussion?				
Ever had a seizure?				
Currently being treated for a seizure disorder or epilepsy?				
Have any problems with his/her hearing or wear hearing aids?				
Have any problems with his/her vision or have vision in one eye only?				
Wear glasses or contacts?				
Has any close relatives been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?				
Has any relative died suddenly before the age of 50 from unknown or heart related cause?				
Are you missing any organs?				

I hereby give consent for my son/daughter _____ to receive a medical physical examination
(Student's Name)
for the purpose of interscholastic athletics by the School Medical Doctor.

Parent/Guardian Print Name:_____

Parent/Guardian Signature:_____