



# Calvary Lutheran High School

Jefferson City, Missouri



## Health Information Form

### Part I: Student Information

(To be completed by student/parent)

Student's Name			Age	Student ID/SSN	Today's Date
Last	First	Middle			
Address			Birth Date - Month/Day/Year	Place of Birth	
City	State	Zip	Student Email Address		Sex
Parent/Guardian			Home Phone	Work Phone	
Name(s)					
Parent/Guardian Email Address			Parent/Guardian Email Address (alternate)		
Emergency Contact Person			Relationship	Contact Phone	Alternate Contact Phone
Name					
Family Physician			City/State		Physician Phone

### Part II: Medical History

(To be completed by parent and verified by health care provider)

Please answer the following questions by circling yes or no. If you answer yes, please explain at the bottom of the form and on back if necessary.

1. Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by doctor?	Yes No	14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity?	Yes No
2. Do you take any medication of any type?	Yes No	15. Is there any other medical or family history which might be important?	Yes No
3. Have you ever had a severe allergic reaction to anything?	Yes No	16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason?	Yes No
4. Have you ever had allergic problems such as hay fever, asthma or eczema?	Yes No	17. Have you ever required taping, padding or bracing before events or practice?	Yes No
5. Do you have difficult breathing or wheezing during or shortly after exercising?	Yes No	18. Do you have damage or absence of one of any paired organs (i.e., kidney, testicle, eye, etc.)?	Yes No
6. Have you ever had a heart murmur, racing heart or irregular heart beat?	Yes No	19. Do you have any skin problems (rash, itching)?	Yes No
7. Have you ever been dizzy or passed out during exercise?	Yes No	20. Do you have any eye or vision problems?	Yes No
8. Has any family member ever had a heart attack or died suddenly before age 50?	Yes No	21. Do you have any ear or hearing problems?	Yes No
9. Do you have chest pain or tire more easily than others your age when exercising?	Yes No	22. What is the most and least you have weighed in the past year?	Least _____ Most _____
10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness or passing out?	Yes No	23. What is the date of your last tetanus booster?	Month/Year
11. Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint?	Yes No	24. What is the date of your last MMR?	Month/Year
12. Have you ever has a concussion or been knocked unconscious?	Yes No	25. How old were you when you had your first menstrual period? <b>Females Only</b>	
13. Have you ever had a seizure?	Yes No	26. In the past year, what is the longest you have gone between menstrual periods? <b>Females Only</b>	

Comments:

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**IMMUNIZATIONS:** To be completed by health care provider. All students must present documentation of month, day, and year of each immunization before they attend school. All immunizations must be up-to-date before students are permitted to attend classes. Missouri requires that students entering grades 8 - 12 must have the following immunizations: **3-DTaP/DTP/DT/Td, 3+ polio, 2 measles, 1 mumps, 1 rubella, 3 hepatitis B.**

Vaccine/Dose	1			2			3			4			5			6			
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																			
Diphtheria and Tetanus (Pediatric DT or Td)																			
Inactivated Polio (IPV)																			
Oral Polio (OPV)																			
Haemophilus influenzae type b (Hib)																			
Hepatitis B (HB)																			
Varicella (Chickenpox)																			
Combined Measles, Mumps and Rubella																			
Measles (Rubeola)																			
Rubella (3-day measles)																			
Mumps																			
Pneumococcal	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			
Check specific type (PCV7, PPV23)																			
Other (Hepatitis A, meningococcal, etc.)																			
Other Specify:																			

**IMMUNIZATION CERTIFICATION:**

\_\_\_\_\_ Student is up-to-date on all immunizations as required by Missouri School Immunization Requirements.

\_\_\_\_\_ Student is "in progress" and needs an additional vaccination(s) of \_\_\_\_\_ on/before \_\_\_\_\_ Date

**PHYSICAL EDUCATION PROGRAM/ATHLETIC PARTICIPATION RECOMMENDATION:**

\_\_\_\_\_ Full and Unlimited Participation

\_\_\_\_\_ Limited Participation **MAY NOT** participate in: \_\_\_\_\_

\_\_\_\_\_ Clearance pending documented follow up of: \_\_\_\_\_

\_\_\_\_\_ **NOT CLEARED FOR ATHLETIC PARTICIPATION** (reason) \_\_\_\_\_

\_\_\_\_\_ Additional Evaluation Suggested: \_\_\_\_\_

\_\_\_\_\_  
Licensed Professional's Name (PRINTED)

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Licensed Professional Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

## Part IV: Student Acceptance

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Part V: Parent Permission and Authorization for Treatment

We hereby give our consent for the above student to participate in physical education classes as well as represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a part, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic or physical education program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We understand that the school may not provide transportation to all events, and **PERMIT / DO NOT PERMIT (CIRCLE ONE)** my child to drive his/her vehicle in such a case.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment, we certify that it is correct and complete.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic athletic insurance coverage. Our son/daughter is covered by basic accident insurance for the current school year with

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(Name of Insurance Company)

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(Policy Number)

(Policy Holder)

Parents or Guardians signature \_\_\_\_\_ Date \_\_\_\_\_  
(all parents or guardians must sign)

\_\_\_\_\_ Date \_\_\_\_\_