

**- Farmington Rockets -
PARTICIPATION HEALTH SCREENING FORM**

(Please turn in no later than the first day of practice, July, 26th 2010 or you may mail to: P.O. Box 314, Farmington, MI 48332)

Child's Name : _____

Home Phone: _____

D.O.B (mm/dd/yy): _____ Sex: M F

Team: ___ JR Fresh. ___ Freshman ___ JV ___ Varsity

Cheerleading Full Contact Football

Physician's Name : _____

Address: _____

Phone: _____

HEALTH HISTORY

<i>Check YES or NO for each</i>	YES	NO
Chronic/Recurring Illness		
Hospitalization		
Surgery other than Tonsils		
Currently taking Medication(s)		
Organs Missing		
Heat Exhaustion /Stroke		
Eye Problems		
Wear Glasses/Contacts		
Dental Appliances/Braces/Etc.		
Severe Headaches		
Head/Brain Injury		
Knocked Unconscious		
Birth Defects		
Problems w/BP		
Problems w/Heart		
Problems w/Kidneys		
Problems w/Spleen/Liver		
Hernia		
Recurrent Skin Disease(s)		
Bone/Joint Injury		
Sprain/Dislocation		
Allergies		
Tetnus/Booster in Last 10 Years		

If you answered "YES" to any of the questions above, please list or explain further: _____

PHYSICIAN APPROVAL

<i>Vitals</i>	YES	NO	<i>Evaluation Comments</i>
Height: _____			
Weight: _____			
Blood Pressure: _____			
Eyes			
ENT			
Dental			
Head			
Chest			
Heart			
Abdomen			
Skin			
Back			
Neck			
Allergies			
General			

Physician Comments: _____

Limitations: _____

The above information is current and correct to the best of my knowledge.

Parent/Legal Guardian Signature Date

Physician Signature Date

PARTICIPANT APPROVED: YES NO

Physician's Office Stamp