Physicians Medical Release 2017-2018 Membership Year

Rower_____
Grade _____ Date of Birth _____

Parent/Legal Guardian
_____

Address _____

City_____ State _____ Zip _____

Home Phone _____ Work Phone

_____ Cell Phone _____

MEDICAL INFORMATION COMPLETED BY PHYSICIAN

Height _____ Weight _____ Date of Last

Tetanus Shot _____

Is patient currently taking or required to have access to prescribed medication? If so, please list medication(s):
_____
_____
_____
_____

Allergies to medication(s)
_____
_____
_____

Are there any significant physical limitations or medical conditions, for example, asthma, seizures, diabetes? If so, please explain:

_____
_____
_____
_____

Physician comments:

_____
_____
_____
_____

Competitive rowing involves prolonged high intensity exercise. I certify that I examined _____ and he/she is physically capable to enroll and compete in supervised rowing activities.

Date of Exam _____

MD's Printed Name _____

MD's Signature

_____

MEDICAL INFORMATION COMPLETED BY PARENT/GUARDIAN

Does the rower have any significant physical limitations or medical conditions, for example, asthma, seizures, diabetes? If so, please explain:

_____
_____
_____
_____

Is the rower allergic to any of the following: insect bites, foods, drugs (Yes or No)? If so, please explain:

_____
_____
_____
_____
_____

Does the rower have any other allergies (Yes or No)? If so please explain:

_____
_____
_____
_____

Is the rower currently taking any medications prescribed by a Physician (Yes or No)? If so, please list:

_____
_____
_____
_____

Rower must have rescue medication available if prescribed. Has the rower sustained any of the following injuries? If so, please explain:

Dislocation of a Joint (Yes or No)?

_____

Broken Bone (Yes or No)?

_____
_____
_____

Other major surgery or injury (Yes or No)?

_____
_____
_____
_____

As parent/guardian of the athlete herein, I further state that I will accept full responsibility for the cost of any injury the student athlete identified herein might suffer while participating in the rowing program and have insurance coverage identified below.

Name of Insurance Company

_____

Policy # _____

Insurance Company Phone _____

Policyholder's Name _____

Family Doctor _____

Phone _____

Local Hospital Preference

_____