

Sports Medical Authorization-Physician's Form

 Valid for **ONE YEAR** only from date of examination.

To be completed by physician.

HT	WT	BP	Vision
Contacts: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Skin: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Musculoskeletal: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Head: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Spine/Scoliosis: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Eyes: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Neck: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Eyes, Nose, Throat: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Shoulders: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Heart: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Hand/arms: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lungs: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Hips: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Knees: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Genitalia: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Ankles: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Neuro: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Feet: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Comments: 			
I certify that _____ is able to participate in interscholastic sports as of _____ (date of exam).			
Physician's Signature: 			
Physician's Name (Please print legibly): 			
Address: 		Phone: 	

Please return completed forms to:
Norwalk River Rowing Association
1 Moodys Lane, Norwalk, CT 06851

Emergency Card / Sport Medical Authorization / Parent's Form

Athlete's Last Name:	First	
Insurance Company	Group #	
Certificate #	Insurance Type	
Employer of Policy Holder	Policy Holder	Policy Holder ID
Doctor's Name (1st choice)	City	Dr's Phone
Doctor's Name (2nd choice)	City	Dr's Phone
Dentist	City	Dentist Phone
In case of emergency, call first:	City	Phone
Emergency Contact (in case parent can't be reached)	Emergency Contact Telephone #	

To be completed by parent (Health history)

TO BE COMPLETED BY PARENT Please check off accordingly (health history)

Asthma: Inhaler: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Diabetes Rx: <input type="checkbox"/> Seizures Rx: <input type="checkbox"/> Cardiac Issues: <input type="checkbox"/> Fainting/dizzy spells: <input type="checkbox"/> EPI-Pen <input type="checkbox"/> YES <input type="checkbox"/> NO	Family History: (e.g. heart attacks, seizures, death under 50 etc.) Significant allergic reactions: Rx
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Significant injury in the last 12 months (e.g. concussions, fractures etc.):

Other significant medical history:

I verify this information is complete and accurate.

Signature _____ Date: _____

**Please return completed forms to:
 Norwalk River Rowing Association
 1 Moodys Lane, Norwalk, CT 06851**

Emergency Medical Authorization

Athlete's Name:

Does your child have any medical conditions that we should be aware of for his/her health and safety?

- No**
 Yes (please explain)

PART 1- YES

In the event that reasonable attempts to contact me (parent/guardian) or the other names listed on the Emergency Card have been unsuccessful, I hereby give my consent for the administration of any emergency treatment necessary by a licensed physician or dentist.

This consent does not cover major surgery unless the medical opinions of two other licensed physicians or dentists are obtained prior to the performance of such surgery.

- Yes**

Signature of Parent of Guardian

Date

OR

PART 2-NO

I DO NOT give consent for any emergency treatment for my child. In the event of illness or injury requiring emergency treatment, I wish authorities of the Norwalk River rowing Association: (please give instructions)

- No**

Signature of Parent of Guardian

Date