Mentoring Through Athletics, Inc
Bowie, Md. 20747
Phone: 301-500-0560
www.mentoringthroughathletics.org

PHYSICAL FITNESS & MEDICAL HISTORY FORM

By completing this form I am acknowledging that I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. He/she also is insured by our family policy with and the information is indicated below. I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team. Additionally, I give my consent and approval for the above below named student to be given medical attention in my absence at the discretion of Mentoring Through Athletics staff.

FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match school report card):

Last _____First_____Middle_____

Address: _____ City: _____ State: _____Zip:_____

Telephone No: _____ Date of Birth: _____ Male____ Female ____

Name of Primary Medical Insurance Company: _____ Policy Number: _____

Membership Number: _____ Name of Primary Insured: _____

Does primary insured have Medicaid? Yes No Does primary insured have Medicare? Yes No

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PARTICIPANT MEDICAL HISTORY

1. Are there any injuries requiring medical attention? Yes No
2. Are there any past surgeries or scheduled surgeries? Yes No
3. Is there any history of concussions and/or head injuries? Yes No
4. Is the participant currently under the care of a medical practitioner? Yes No
5. Is the participant currently taking any medications? Yes No
6. Does the participant have any allergies (penicillin, bee stings, etc)? Yes No
7. Does the participant have asthma/require the use of an inhaler? Yes No
8. Is the participant diabetic/require medication for diabetes? Yes No
9. Does the participant carry sickle cell trait/suffer from sickle cell disease? Yes No
10. Does the participant currently require medication? Yes No
11. Does/has the participant have/had seizures? Yes No
12. Does the participant wear glasses or contact lenses? Yes No
13. Does the participant wear a brace or other medical support device? Yes No
14. Does the participant have any other physical limitations or medical conditions? Yes No

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space and/or attach to this form: _____
_____
_____

I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided by MTA in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization officially in writing if there is any change in the medical condition of my child. I also understand that it's my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signature of Parent or Legal Guardian: _____

Print Name_____

Relationship to Participant_____ Dated_____