

*PARENT OR GUARDIAN PERMIT  
FOR ATHLETIC PARTICIPATION*

NAME \_\_\_\_\_ DATE. \_\_\_\_\_

I hereby give my consent for the above named to compete in approved sports and go with the coach on any approved trips.

In any sport, there is a chance a participant can be injured. In a small percentage of cases, a participant could sustain very serious injury. It is understood that the school assumes no responsibility in case an accident or injury occurs. The school does carry supplemental insurance which will help defray cost that your insurance does not pay.

We furnish NOCSAE approved headgears in football. We have advised each athlete that no helmet can prevent all head and neck injuries, and of the dangers of butt blocking, ramming, and spearing. We have also advised him of the need to constantly check all equipment and report any deficiencies to the coaches immediately.

I give my consent, in case an accident or injury occurs, for the coaches to secure treatment at the best facilities available to them.

My son/daughter is allergic to \_\_\_\_\_ Medication

My son/daughter's most recent tetanus shot was on \_\_\_\_\_

Please list all pre-existing illnesses or injuries \_\_\_\_\_

Parent or Guardian's Phone \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Home \_\_\_\_\_

Business \_\_\_\_\_

Insurance Information \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group Number \_\_\_\_\_

Parent or Guardian's mailing address \_\_\_\_\_

Parent or Guardian's e-mail address \_\_\_\_\_

## ATHLETIC COMPETITION HEALTH SCREENING FORM

NAME:			FAMILY PHYSICIAN:		
SCHOOL:			SPORTS:		
AGE:		GRADE:		----- 1-	
DATE OF BIRTH: _ / _ / __			SEX: F M		
HEALTH HISTORY PARENT OR GUARDIAN Answer "yes" or "no" ONLY			VITALS	PHYSICAL EVALUATION COMMENTS	RECOMMENDED FOLLOW-UP
	YES	NO	Ht		
Chronic/Recurrent Illness:			Wt    lbs.		
Hospitalization?			BP    /		
Surgery Other Than Tonsils?			General		
Injuries Treated by Physician?					
Current Medications?					
Organ Missing?					
Heat Exhaustion/Stroke?			Head		
Dizziness, Fainting, Convulsion and/ or Headaches?					
Knocked Out?					
Concussion?			Eyes	<p style="text-align: center; margin-top: 0;">ORTHOPEDIC EVALUATION</p> <hr/> <p>Summary of Comments:</p> <hr/> <p style="text-align: center;">SPORTS PARTICIPATION APPROVED YES NO</p> <p>Limitations:</p>	
Wears Glasses or Contacts?			ENT		
Hearing Defects?			Heart		
Problems with Blood Pressure Heart or Murmurs?			Abdomen		
Problems with Liver, Spleen, Kidney?			Genitalia		
Hernia?			Extremity Back Neck		
Bone/Joint Injury?					
Sprains/ Dislocation?			Allergy		
Allergy to Medications?					
Name:					
Tetanus Booster in the last 10 Years?					

Parent or Guardian Signature

PHYSICIAN SIGNATURE

\_\_\_\_\_

\_\_\_\_\_

