

Holy Child Academy

Parental Permission & Health History for Interscholastic Athletics (Completed form required for students in grades 5 –8)

Dear Parent or Guardian:

Your son/daughter wishes to participate in interscholastic athletics. New York State law requires that participants have parental permission, provide medical history, and have a sports screening/physical examination.

This form must be completed and returned to your child's coach or the school's Athletic Director before your child can participate in any interscholastic activities.

Bob Kratochvil, Athletic Director

Certificate of Health

(This side to be completed by parent/guardian)

Student: _____ Birth Date: _____ Sex: _____ Age: _____
(PLEASE PRINT) LAST FIRST

Parent/Guardian: _____ Home Phone # () _____

Home Address: _____ Work Phone # () _____

_____ Cell Phone # () _____

If not available in an emergency, please notify:

Name: _____ Phone # () _____

Name: _____ Phone # () _____

Parental Permission

I hereby give my daughter/son _____ permission to participate in interscholastic athletics for the _____ / _____ school year. I acknowledge that there are risks involved in sports activities.

(Parent/Guardian Signature)

(Student Signature)

(Date)

(Date)

OVER PLEASE ...

Physical Examination

(To be completed by physician)

Student: _____ Grade: _____ Age: _____

Address: _____ Phone # _____

Height: _____ Weight: _____ Blood Pressure: _____

Pulse: _____ Pulse: _____ Pulse: _____

(NORMAL)

(HOP 25 TIMES)

(2-MINUTE REST)

Check Any Problems in the Following Areas:

Heart: _____ Lungs: _____ Hernia: _____ Scoliosis: _____ Urine: _____

Did student participate in interscholastic athletics last year? Yes: _____ No: _____

Did student sustain a serious injury or illness in the last year? Yes: _____ No: _____

Is student on any medication that may interfere with participation? Yes: _____ No: _____

If yes, please explain: _____

Any feeling of dizziness or fatigue after heavy exertion? Yes: _____ No: _____

Has student ever had any fractures, dislocations, severe sprains or chronic diseases? Yes: _____ No: _____

Does student have allergies? Yes: _____ No: _____

If yes, please explain: _____

Does student wear glasses? _____ Contact Lenses? _____

Any history of loss of consciousness? Yes: _____ No: _____

If yes, please explain: _____

Are there any medical problems that we should be aware of? Yes: _____ No: _____

If yes, please explain: _____

Student May Participate in Contact Sports: (Please Check)

1. Soccer: _____ 4. Softball: _____ 7. Other: _____

2. Basketball: _____ 5. Tennis: _____

3. Lacrosse: _____ 6. Volleyball: _____

I certify that the above named student is physically qualified to participate in the interscholastic athletic program at Holy Child Academy.

Physicians Signature: _____ Date: _____

Phone #: _____