SAINT CHRISTOPHER SCHOOL
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PARENTAL PERMISSION
FOR PARTICIPATION IN ATHLETIC PROGRAM

Student's name_____Grade_____Home Room_____
Address_____Zip_____Home TelePhone_____
Age_____Date of Birth_____Family Physician _____
Physician's Phone #_____Hospital Preference_____

It is my understanding that my child **WILL NOT** be allowed to practice or participate until the physical examination, along with the parental permission, is completed and returned to the school nurse for review.

PLEASE NOTE:
RESTRICTION: Any operation, serious accident or long-term illness will require a physician's certificate granting the student-athletic permission to participate.

I hereby give permission for the above student to participate in organized school athletics for the_____year as part of the sports program. Completing this form and having a physical completed will enable the student to participate in any sport activity during the school year. **I REALIZE THAT SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY WHICH IS INHERENT IN ALL SPORTS. I ACKNOWLEDGE THAT EVEN WITH THE BEST COACHING AND STRICT OBSERVANCE OF RULES, INJURIES ARE STILL POSSIBILITY. ON RARE OCCASIONS, THESE INJURIES CAN BE SO SEVERE AS TO RESULT IN TOTAL DISABILITY, PARALYSIS OR EVEN DEATH. I ALSO DECLARE THAT THE ABOVE STUDENT HAS NOT RECEIVED ANY PREVIOUS PHYSICAL INJURY AND HAS NO PHYSICAL DISABILITY WHICH MAY JEOPARDIZE OR BE AGGRAVATED BY THE SPORT IN WHICH HE/SHE IS ALLOWED TO PARTICIPATE.**

PARENT/GUARDIAN SIGNATURE_____DATE_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

Please answer the questions and sign at the x.

HISTORY

Student's Name_____**Age:**_____

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

Physician's Direction: We recommend repeating the 15 questions listed below and carefully reviewing details of any positive answers.

Yes	No	Don't Know	If yes is checked for any of these questions, please clarify.
☐	☐	☐	1. Has anyone in the athlete's family (grandmother, mother, father, brother, sister, aunt, uncle) died suddenly before the age of 50 years?
☐	☐	☐	2, Has the athlete ever passed out during exercise or stopped exercising because of dizziness?
☐	☐	☐	3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
☐	☐	☐	4. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
☐	☐	☐	5. Does the athlete have a history of a concussion (getting knocked out)?
☐	☐	☐	6. Has the athlete ever suffered a heat-related illness (heat stoke)?
☐	☐	☐	7. Does the athlete have anything he or she wants to discuss with the physician?
☐	☐	☐	8. Does the athlete have a chronic illness or see a physician regularly for any particular problem?
☐	☐	☐	9. Does the athlete take any medicine?
☐	☐	☐	10. Is the athlete allergic to any medications or to bee stings?
☐	☐	☐	11. Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?
☐	☐	☐	12. Does student wear contact lenses or braces?
☐	☐	☐	13. During exercise, does the athlete pass out or get dizzy, have chest pain or palpitations or shortness of breath?
☐	☐	☐	14. If athlete is a female, does she have a normal menses?
☐	☐	☐	15. Has the athlete had any injuries since the last doctor's visit?

Elaborate on any positive answers.

The exam is being done by my private physician_____.
I have answered and reviewed the questions above and give permission for my child to participate in sports.

Signature or Parent or Guardian **x**_____Date_____

Evening Phone_____Day Phone_____

PHYSICAL EXAMINATION Description of Abnormal Findings.

PHYSICAL EXAMINATION DATE _____

1. BP_____WT._____HT._____
   Urinalysis_____
2. Musculoskeletal examination
   HCT/HGB_____

(Record taxity, weakness, instability, decreased ROM if abnormal)

Normal	Abnormal	
_____	_____	A. Knee
_____	_____	B. Ankle
_____	_____	C. Shoulder
_____	_____	D. Other joints
_____	_____	E. Alignment problems (e.g., leg length, or angle)
_____	_____	F. Scoliosis
_____	_____	G. Feet
_____	_____	H. Estimate of strength
_____	_____	I. Estimate of flexibility

3. Cardiovascular examination
4. Other examination (if indicated by history)

ASSESSMENT

5. A._____ No problems identified
   B._____ Other

RECOMMENDATIONS

6. A.____ Unlimited
   B.____ Limited to specific sports.
   C.____ Deferred until.
   (e.g., rehabilitation, recheck, consultation, laboratory tests, etc.)

REEXAMINE

7. A.____ Yearly and after any injury that limits participation for longer than 1 week.
   B.____ Other.
8. Date of last dt or td _____

Physician's Signature_____

Physician's Name_____