FALLSBURG CENTRAL SCHOOL DISTRICT SPORTS HEALTH UP-DATE / PARENT PERMISSION FORM
RETURN THIS FORM TO YOUR SCHOOL NURSE

STUDENT NAME: _____ GRADE:_____ SEX: (M/F)_____ DOB: _____
ADDRESS: _____ HOME PHONE: _____
SPORT: _____ _____LEVEL: (circle one) MOD FRESH JV VAR
PARENT / GUARDIAN NAME: _____ _____ TEL: (w) _____ (Emergency Number): _____
NAME OF FAMILY DOCTOR: _____ TELEPHONE NUMBER OF FAMILY DOCTOR: _____

I HEREBY APPLY FOR THE PRIVELEGE OF TRYING OUT FOR THE ABOVE SPORT AND FULLY RECOGNIZE MY RESPSONSIBILITIES. I WILL BEHAVE IN A MANNER THAT WILL BE A CREDIT TO MY SCHOOL AND SPORT. I REALIZE THAT I MAY BE ASKED TO WITHDRAW FROM THE TEAM IN CASE I DO NOT. IF EXTENDED THE ABOVE PRIVELEGE, I WILL FOLLOW THE REGULATIONS IN THE ATHLETIC CODE AND ANY ADDITIONAL TRAINING RULES GIVEN TO ME BY MY COACH.

_____ (STUDENT SIGNATURE)

MEDICAL HISTORY	Y	N	MEDICAL HISTORY	Y	N
Have you ever had a medical illness or injury since your last check up or sports physical?			Do you wear glasses or contacts?		
Have you been seen in the emergency room? Have you ever been hospitalized overnight?			Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?			Have you had any problems with your eyes or visions?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			Have you ever had a sprain, strain, or swelling after injury?		
Do you have any allergies (for example, to pollen, medicine, food, or stringing insects)?			Have you broken or fractured any bones or dislocated any joints?		
Do you carry an Epipen? Have you ever passed out during or after exercise?			Have you had any other problems with pain or swelling muscles, tendons, bones, or joints? *If yes, check appropriate choice and explain below.* ___Head ___Elbow ___Hip ___Neck ___Forearm ___Thigh ___Back ___Wrist ___Knee ___Chest ___Hand ___Ankle ___Shin/Calf ___Shoulder ___Finger ___Foot ___Upper Arm		
Have you ever been dizzy during or after exercise?					
Have you ever had chest pain during or after exercise?					
Have you ever become ill from exercising in the heat?					
Have you ever been told you have a heart murmur?					
Has any family member or relative died of heart problems or of sudden death before age 50?					
Has a physician ever denied or restricted your participation in sports for any heart problems?			Do you have asthma?		
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?			Do you cough, wheeze, or have trouble breathing during or after activity?		
Have you ever had a head injury or concussion? If so when?			**FEMALES ONLY**		
Have you ever been knocked out, become unconscious, or lost your memory?			When was your first menstrual period?		
Have you ever had a seizure?			When was your most recent menstrual period?		
Do you have frequent or severe headaches?					

If you answered yes to any question, please explain here: _____

I have read and understand the concussion policy _____ _____
(Parent signature) (Student signature)

***List any chronic conditions here:** _____

I am fully aware that there is a risk of physical injury in all sports participation. School provided insurance might not cover all medical expenses in case of injury.
In case of an accident, I give the coach permission to obtain medical treatment of my child if I cannot be contacted. My insurance information is:

Company Name: _____ Policy Number: _____

If needed, the physical will be performed by: € **My family physician** € **Fallsburg Central School doctor**

I certify that all the above information is correct _____ _____
(Signature of Parent or Guardian) (Date signed)

(SCHOOL USE ONLY)

THE ABOVE NAMED STUDENT HAS HAD A PHYSICAL EXAMINATION AND IS APPROVED TO COMPETE IN SPORTS AS PER THE HEALTH CARE PROVIDER DURING THE _____ SEASON OF THE _____ SCHOOL YEAR. B.P_____

Restrictions (if any): _____

DATE OF PHYSICAL: _____ FALLSBURG CSD NURSE'S SIGNATURE:_____