

McQUAID JESUIT HIGH SCHOOL ATHLETIC FORM

Sport _____
 Season _____
 Grade _____



Student Name _____ Birthdate _____ Age _____
 Name of Parent _____ Home Phone: _____
 Address and Zip _____ Business Phone: _____
 Emergency Person _____ Emergency Phone: _____
 Physician's Name _____ Physician's Phone: _____
 Preferred Hospital _____ Dentist's Phone: _____

Prior to the start of tryout practice sessions at the beginning of each season a health history review for each athlete must be conducted.

SINCE THE LAST HEALTH HISTORY for athletic participation Form was completed has the athlete

PLEASE, ALSO ANSWER THE FOLLOWING QUESTIONS:

- | | Yes | No | | Yes | No |
|--|-------|-------|---|-------|-------|
| 1. Sustained any injury which required medical attention: | _____ | _____ | 1. Is there any family history of sudden death due to heart disease in family members less than fifty years of age? | _____ | _____ |
| a. If YES has the problem been fully resolved? | _____ | _____ | 2. Had any teeth capped or replaced artificially? | _____ | _____ |
| b. If NO, your child will need to be cleared by your private physician or by the school physician before being allowed to participate. Please indicate choice below: | | | 3. Been fitted for braces? If YES, is a mouthpiece from an orthodontist necessary? | _____ | _____ |
| _____ I will provide a certificate from my private physician. | _____ | _____ | 4. Required glasses for sport? If YES, are glasses impact resistant? | _____ | _____ |
| _____ Please have my child cleared by the school physician. | | | 5. Is there any medical condition or restriction which may be exacerbated by playing sports? | _____ | _____ |
| 2. Had any illnesses which lasted longer than one week or required any surgery? | _____ | _____ | 6. Is this athlete under a physician's care now for any existing problem? | _____ | _____ |
| 3. Required any ongoing medication? | _____ | _____ | 7. Are there any known allergies to medicines? | _____ | _____ |
| 4. Had a convulsion? | _____ | _____ | 8. Last tetanus vaccination. Date _____ | _____ | _____ |
| 5. Complained of chest pain or fainting during physical exertion? | _____ | _____ | | | |

If YES to any questions, explain by number: _____

Parent: I have carefully read and understand the above. To the best of my knowledge there is no existing condition that should exclude my son/daughter from athletic participation. My signature below constitutes my permission for my child to participate in the above named sport. I understand that McQuaid does not assume responsibility for lost or broken corrective lenses or orthodontic devices. In the event of an emergency, and I cannot be reached, my signature below constitutes my permission for my child to receive medical evaluation and necessary treatment to ensure his/her health and safety. Such treatment may come from either my child's physician or an emergency room physician in the event our family physician cannot be contacted.

Parent's Signature _____ Date _____

I give my son permission to drive/ride with another player or coach to activities related to the above sport. Parent's

Signature _____ Date _____

INTERSCHOLASTIC ATHLETIC POLICY ON DRUGS/ALCOHOL

We hereby agree to the terms of McQuaid's Interscholastic Athletic Policy on Drugs/Alcohol.

Parent's Signature _____ Student's Signature _____

Date _____ Date _____

Sport _____ LEVEL: Varsity J.V. Freshman (circle one)

For Office Use Only

Date of last physical exam: _____ . This certifies that _____ is physically qualified to participate in the sport indicated above.

Date M.D. note on file for release (include name of M.D.) _____

Date: _____ Signature: _____

Signature of School Nurse

THIS CERTIFICATE IS VOID IF PUPIL IS ABSENT FOR 5 OR MORE CONSECUTIVE DAYS BECAUSE OF ILLNESS OR HAS SUSTAINED SIGNIFICANT INJURY. A HEALTH HISTORY REVIEW IS REQUIRED FOR REENTRY.

Please return three completed copies of this form to the nurse