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:

	Yes	No
1. Sustained any injury which required medical attention:	____	____
a. If YES has the problem been fully resolved?	____	____
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:	____	____
____I will provide a certificate from my private physician.		
____Please have my child cleared by the school physician.		
2. Had any illnesses which lasted longer than one week or required any surgery?	____	____
3. Required any ongoing medication?	____	____
4. Had a convulsion?	____	____
5. Complained of chest pain or fainting during physical exertion?	____	____

PLEASE, ALSO ANSWER THE FOLLOWING QUESTIONS:

	Yes	No
1. Is there any family history of sudden death due to heart disease in family members less than fifty years of age?	____	____
2. Had any teeth capped or replaced artificially?	____	____
3. Been fitted for braces? If YES, is a mouthpiece from an orthodontist necessary?	____	____
4. Required glasses for sport? If YES, are glasses impact resistant?	____	____
5. Is there any medical condition or restriction which may be exacerbated by playing sports?	____	____
6. Is this athlete under a physician's care now for any existing problem?	____	____
7. Are there any known allergies to medicines?	____	____
8. Last tetanus vaccination. Date _____		

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 Modified (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.

Coach - white copy
Athletic Director - yellow copy
Nurse - pink copy