JEFFERSON CENTRAL SCHOOL

SPORTS PARTICIPATION INFORMATION
&
INTERVAL HEALTH HISTORY

THIS FORM MUST BE COMPLETED BY THE PARENTS OR LEGAL GUARDIAN AND ON FILE PRIOR TO THE START OF EACH SPORTS SEASON.

PART A: TO BE COMPLETED BY PARENTS OR GUARDIAN

Student: _____ Age: _____

THIS FORM IS INTENDED FOR ONE ATHLETE ONLY.

Grade (check): ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 Date of Birth: ___/___/___

Emergency Contact Information

Parents Name: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

I give permission for emergency medical care in the event I cannot be reached.

Signed: _____ **Date:** ___/___/___
Parent or Legal Guardian

Signed: _____ **Date:** ___/___/___
Student Athlete

Notes: _____

_____

Was the last Health Examination conducted by the School Physician: ☐**Yes** ☐**No**

If the answer to the above question is 'No", then a copy of the Health Examination **MUST** be on file in the Health Office prior to the start of the sports season.

Date of last Health Examination: ___/___/___

PART B: TO BE COMPLETED BY PARENTS OR GUARDIAN

HISTORY SINCE LAST HEALTH EXAMINATION

Note: "Yes" to any of these questions does not mean automatic disqualification from the athletic activity indicated in PART A above. However, it may require a review and approval by the school physician before the student can participate in practice. The answers to the questions on this form will be held in the school health office, and will be kept confidential.

1.	Any injuries requiring medical attention?	☐ **Yes**	☐ **No**
2.	Any illness lasting more than five (5) days?	☐ **Yes**	☐ **No**
3.	Taking Medicine or under physician's care at this time?	☐ **Yes**	☐ **No**
4.	Any feeling of faintness, dizziness or fatigue after exercise or exertion?	☐ **Yes**	☐ **No**
5.	Change in wearing glasses or contact lenses?	☐ **Yes**	☐ **No**
6.	Any surgical operation or fractures?	☐ **Yes**	☐ **No**
7.	Any treatment in a hospital or emergency room?	☐ **Yes**	☐ **No**
8.	Developed any allergies?	☐ **Yes**	☐ **No**
9.	Any chronic disease?	☐ **Yes**	☐ **No**
10.	Any limitations?	☐ **Yes**	☐ **No**

Describe the condition that caused any question(s) to be answered "**Yes**".

_____

_____

PART C: PARENTAL PERMISSION

I, the undersigned, clearly understand that these questions are being asked in order to determine if my child can safely participate on the athletic team named in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED:_____ DATE:___/___/___

PART D: TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports participation: ☐ **Approved** ☐ **Referred to School Physician**

Signed _____ Date ___/___/___
School Health Office

If referred to the School Physician: ☐ **Re-qualified** ☐ **Disqualified**

Signed _____ Date ___/___/___
School Physician