

RECERTIFICATION FOR SPORTS PARTICIPATION

INTERIM HEALTH HISTORY

must be completed and signed by parent or guardian

Date _____

FR/SOPH/JR/SR
(circle one)

PERSONAL INFORMATION

Name _____ Enrolled in _____ School _____

Sport _____ Age _____

Home Address _____ Phone _____

Parent/Guardian _____ Phone _____

Family Physician _____ Phone _____

Within the past year has the student had:

YES	NO	EXPLAIN
Y	N	Any injury related to sports _____
Y	N	Any injuries not related to sports _____
Y	N	Any operations _____
Y	N	Any illness requiring student to stay home or be hospitalized _____
Y	N	Experienced dizzy spells or blackouts or unconsciousness _____
Y	N	Any episodes of unexplained shortness of breath, wheezing, or chest pain _____
Y	N	Any new health problems _____
Y	N	Any new medications, prescription or over-the-counter _____
Y	N	Any health problems student wants to discuss with a doctor _____

Parent/Guardian Signature

Date

Must be completed and signed by medical personnel performing student's recertification

Height _____ Weight _____ BP _____ / _____ Pulse _____ Handed R _____ or L _____

Clearance for sports participation:

A. Cleared

B. Cleared after completing evaluation / rehabilitation for: _____

C. Not Cleared for Collision Contact Noncontact Strenuous Moderately Strenuous Nonstrenuous

Due to: _____

Recommendation/Referral: _____

Name of Medical Examiner: _____ Date: _____

Address: _____ Phone _____

Signature MD, DO, PAC, CRNP, SNP _____

SOUTHERN LEHIGH SCHOOL DISTRICT

Sports Participation Permission

Name of Student _____

Sport _____

Grade _____

Insurance Waiver Information

I hereby certify that my child now, and for the remainder of the current school year is insured in a manner satisfactory to me to cover any injuries sustained by him/her in going to and from school and participation in school activities including interscholastic athletics.

Signature of Parent/Guardian _____

Parent/Guardian Permission

I hereby give my permission for my daughter/son to engage in the state association approved athletic activities as a representative of his/her school. I give consent for the above student to accompany the team as a member on its out-of-town trips. I realize that participation in school athletics involves some medical risks.

Signature of Parent/Guardian _____

Publication Permission

At times, representatives of various news media cover certain school events. This coverage includes both public media and School District media. An outcome may be a desire to publish information and/or picture about these events and our schools. This could occur, for example, in local newspapers or television programs, as well as the District or building newsletter. We would like to have your permission on file so that, in the event that your child's picture, comments, and/or name are selected for publication, we can proceed.

Signature of Parent/Guardian _____

Sports Physical

I give my consent for the above-named student to be examined by the St. Luke's physicians. The doctors will be providing a comprehensive sports history and physical pre-participation screening examination. The purpose of this exam is to ensure that your child can safely participate in athletics. This exam is not intended to replace your child's routine health maintenance examination with their primary physician. Discussions regarding high-risk teen-age behaviors, the importance of diet and exercise, testicular exams, and treatment of injuries or illnesses will not be conducted.

Signature of Parent/ Guardian _____

10/2007

SOUTHERN LEHIGH SCHOOL DISTRICT

Athletic Emergency Information Form

(please print clearly in pen)

Name _____
 (Last, first name)
 Address _____

Sport _____
 DOB _____
 Grade _____

Parent/Guardian Information

Parent/Guardian _____ Home Phone _____
 Mother's Work Phone _____ Father's Work Phone _____
 Mother's Cell Phone _____ Father's Cell Phone _____
 Alternate Emergency Contact _____ Phone _____

Family Physician _____ Phone _____
 Primary Health Information _____
 Do you need a referral from your family doctor? Yes ___ No ___

Medical History

- | | | | |
|--|--|-----|-----|
| 1. Previous fracture/dislocation/separation: _____ | Have you ever had or do you have now? | | |
| | | Yes | No |
| 2. Previous surgery: _____ | Concussion | ___ | ___ |
| | Heat Illness | ___ | ___ |
| 3. Are you an insulin dependent diabetic? _____ | Dizziness | ___ | ___ |
| | Convulsions/Seizures | ___ | ___ |
| 4. Do you wear glasses or contacts? _____ | Epilepsy | ___ | ___ |
| 5. Do you have asthma? _____ | Heart Trouble | ___ | ___ |
| Do you use an inhaler? _____ | Chest Pains | ___ | ___ |
| 6. Do you have allergies? _____ | High Blood Pressure | ___ | ___ |
| If yes, please explain _____ | Hernia or Rupture | ___ | ___ |
| 7. Do you take medication? _____ | Mononucleosis | ___ | ___ |
| If yes, please explain _____ | | | |
| 8. Do you use an Epi-pen? _____ | If yes to any of the above, please explain _____ | | |

If you have any medical conditions not listed, please explain _____

Authorization for Emergency Medical Treatment

I, hereby give permission for emergency treatment by the team of physician and/or trainer for conditions arising from participation in athletics. This will include, but not be limited to; initial diagnostic x-rays and other procedures as the physician may see necessary for the preservation of health. In the event that it is necessary to have my child transported by ambulance to a hospital, I give permission for my child to be taken to _____.

Parent/Guardian Signature

Date _____