Greece Christian School

ATHLETIC PROGRAM PERMISSION SLIP AND MEDICAL RECERTIFICATION

Sport _____

Student Name _____ Season _____

Grade _____ Birthdate _____ Age _____

Name of Parent _____ Home Phone _____

Address and Zip _____ Business Phone _____

Person to call if unable to reach parent _____ Emergency Phone _____

Physician's Name _____ Physician's Phone _____

Dentist's Name _____ Dentist's Phone _____

Preferred Hospital _____ Cell/Pager _____

*****Prior to the start of 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 fully resolved?	___	___
b. If NO, your child will need to be cleared by your private physician before being allowed to participate.	___	___
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?	___	___
6. Is there any family history of sudden death?	___	___
7. Had any teeth capped or replaced artificially?	___	___
8. Been fitted for braces? If YES, is a mouthpiece from an orthodontist necessary?	___	___
9. Required glasses for sports? If YES, are glasses impact resistant?	___	___
10. Started using contact lenses?	___	___
11. Is there any medical condition/restriction which may be exacerbated by playing sports?	___	___
12. Is this athlete under a physician's care?	___	___
13. Are there any known allergies to medicine?	___	___
14. 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 Northstar 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 Signature _____ Date _____

For Office Use Only

Date of last physical exam _____. This certifies that _____

Is physically qualified to participate in the sport indicated above. Date last physical on file _____

Date _____ Signature _____

Signature of School Nurse

THIS CERTIFICATE IS VOID IF PUPIL SUSTAINS A SIGNIFICANT INJURY, A HEALTH HISTORY REVIEW AND CLEARANCE BY PERSONAL PHYSICAIN IS REQUIRED FOR RE-ENTRY.