NEW CANAAN HIGH SCHOOL
11 FARM ROAD, NEW CANAAN, CT 06840
PHONE: 203-594-4640 FAX: 203-594-4701

SPORTS MEDICAL AUTHORIZATION FORM

(Valid for ONE YEAR ONLY from date of examination)

STUDENT NAME_____ **PHONE**_____

ADDRESS_____ **YR OF GRADUATION**_____

DATE OF BIRTH_____/___/_____ **DATE OF PHYSICAL EXAM**_____/___/_____

TO BE COMPLETED BY PARENT: Please Check:

(Health/History)

- **O** Asthma Rx_____ Inhaler: Yes No
- **O** Diabetes Rx_____
- **O** Seizures Rx_____
- **O** Cardiac: Student-Athlete_____
  Family History: (e.g.; heart attacks, death under age 50)_____
- **O** Significant systemic allergic reactions: Rx_____ Epi-pen: Yes No
- **O** Significant injury in past 12 months: (e.g.; concussion, fractures, surgery)_____
- **O** Fainting, dizzy spells:_____
- **O** Other significant medical history:_____

_____

_____Today's Date:_____

Parent Signature – Please complete and sign

TO BE COMPLETED BY CERTIFIED PHYSICIAN:

HT_____WT_____B.P._____H.R._____Vision_____Contacts_____Hearing____

	Normal	Abnormal		Normal	Abnormal
Skin			Musculoskeletal		
Head			Spine/Scoliosis		
Eyes			Neck		
ENT			Shoulders		
Heart			Hands/Arms		
Lungs			Hips		
Abdomen			Knees		
Genitalia			Ankles		
Neurological			Feet		

COMMENTS:

I certify that (Name)_____is able to participate in interscholastic sports as of _____/_____/_____***(DATE OF EXAM)***.

_____ _____

Physician's Signature Address

_____ _____

Physician's Name-PRINT Phone