Dear Parents/Guardians,

It is mandatory that all students engaging in Interscholastic Athletics have a comprehensive health appraisal to determine if they are medically eligible to participate. No student is allowed to participate in tryouts or practice without completion and approval of medical history and examinations.

Ideally, this examination can best be done by your own physician who knows him/her well, and should include a full history and physical examination, as well as height, weight, blood pressure, urinalysis, vision, hematocrit, pulse, Tine or PPD as indicated.

A thorough baseline physical with a completed and signed, sports participation permission form and medical history are required.

Evidence of an examination by a physician, completed on this form, withing the previous twelve (12) months is sufficient providing that there have been no injuries or major illness since that time. If an injury has occurred in the interim, a medical clearance obtained from your physician must be submitted to the nurse before student can resume sports participation

Attached are forms which you and your physician must complete and sign after the examination is finished. It is important that you return these forms to the school nurse as soon as possible, along with a signed permission for medical treatment card.

TO BE COMPLETED BY PARENT/GUARDIAN

SPORTS PARTICIPATION PERMISSION FORM

STUDENTNAME_____

I HEREBY (DO ___ DON'T___) (check one) GRANT PERMISSION FOR MY (SON/DAUGHTER/WARD) TO TAKE PART IN INTERSCHOLASTIC SHOOL ATHLETIC ACTIVITIES FOR THE SCHOOL YEAR _____.
(School Year)

I realize that such activity involves the potential for injury, which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so sever as to result in total disability, paralysis or even death.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE BELOW STATEMENTS.

Parent/Guardian_____ Date_____

Address_____ Telephone_____

Family Doctor's Examination_____ Date_____

ATHLETIC INSURANCE COVERAGE

Stamford Public Schools Interscholastic Insurance Policy provides excess type benefits that pick up when other coverage leaves off.

Players and parents must first submit th injury claim through their own personal insurance coverage, if any and then this plan will pay only the usual and reasonable medical expenses not provided or reimbursed under the other coverage.

If a parent doen't carry medical insurance, this plan will cover all usual and reasonable expenses related to the injury.

Some of the major points in the policy are:

Maximum Benefit	$10,000.00
Maximum Dental Benefits	$1,000.00
Deductible	None
Dismemberment Benefit	$10,000.00

PLEASE NOTE; ANY FALSE SIGNATURE WILL SUBJECT THE STUDENT TO EXCLUSION FROM THE INTERSCHOLASTIC SPORT OR SPORTS

TO BE COMPLETED BY PARENT/GUARDIAN
SPORTS MEDICAL HISTORY

STUDENTNAME_____

	NO	YES
1. Are there any birth defects?	___	___
2. Have any members of you family under age 50 had a "heart attack" or "heart problems?"	___	___
3. Have you ever been told you have a heart murmur, high blood pressure, extra heart beats, or heart abnormality?	___	___
4. Do you get short of breath easily or have to stop while running around A track twice (¼ mile)?	___	___
5. Are you taking any medications? If so, what?	___	___
6. Have you ever had any illnesses, or condition, or injury that:		
a. Required you to go to the hospital as a patient overnight or in the Emergency room for any X-rays?	___	___
b. Required an operation? If yes, what?	___	___
c. Lasted longer than one week? If yes, what?	___	___
d. Caused you to miss a game or practice? If yes, what?	___	___
e. Is related to allergies (hives, hay fever, asthma, or medicine)? If yes, what?	___	___
8. Do you bleed or bruise easily?	___	___
9. Do you have any shoulder pains, elbow pains, back pains, or knee pains?	___	___

EXPLANATION OF ANY YES ANSWERS FROM ABOVE

To the best of my knowledge, my answers to the above questions are correct.

_____ _____

Signature of Parent/Guardian Date

TO BE COMPLETED BY PHYSICAIN

STAMFORD ATHLETIC PHYSICAL EXAM

NAME_____ SCHOOL_____

ADDRESS_____ SPORT_____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____ BLOOD PRESSURE (SITTING) RA ___/___

PULSE _____ VISION L 20/___ R 20/___ GLASSES L _____ R _____

HEARING _____ SCOLIOSIS _____ URINALYSIS _____

HGB/HEMATOCRIT _____ LAST TETANUS _____ TB TEST _____

		CHECK IF NEGATIVE
SKIN		_____
PUPILS L ___ R ___		_____
MOUTH		_____
LYMPHATICUS:	CERVICAL	_____
	AXILLARY	_____
CHEST:	P.I.	_____
	PULSE	_____
	RHYTHM	_____
	LUNGS	_____
ABDOMEN ORGANS:		
GENITALIA	MATURATION INDEX	_____
	HERNIA/SCROTUM	_____
ORTHOPEDIC:	CERVICAL SPINE/BACK	_____
	SHOULDERS	_____
	ARM/ELBOW/WRIST/GRIP	_____
	KNEES	_____
	ANKLE	_____

"I CERTIFY THAT I HAVE ON THIS DATE EXAMINED THIS STUDENT AND THAT, ON THE BASIS OF THE EXAMINATION REQUESTED BY THE SCHOOL AUTHORITIES AND THE STUDENTS MEDICAL HISTORY AS FURNISHED TO ME, I HAVE FOUND NO REASON WHICH WOULD MAKE IT MEDICALLY IN ADVISABLE FOR THIS STUDENT TO COMPETE IN SUPERVISED ATHLETIC ACTIVITIES, EXCEPT THOSE CROSSED OUT."

BASEBALL	BASKETBALL	SWIMMING	FOOTBALL	GOLF
FIELD HOCKEY	GYMNASTIC	ICE HOCKEY	CROSS COUNTRY	SOCCER
SOFTBALL	TENNIS	INDOOR TRACK	VOLLEYBALL	TRACK
WRESTLING	CHEERLEADING			

PHYSICIAN RECOMMENDATIONS: _____

_____

EXPLANATION OF ANY POSITIVE FINDINGS _____

_____

PHYSICIAN _____ DATE OF EXAMINATION _____