

BISHOP KEARNEY HIGH SCHOOL
SPORTS MEDICAL FORM
2202 60TH STREET BROOKLYN, NY 11204/ PHONE: (718) 236-6363/ FAX: (718) 236-7784

REQUIRED TO TRY-OUT FOR ALL SPORTS

Dear Parent/Guardian,

This form must be submitted by Tuesday, August 15, 2017 and completed on both sides and given to the Medical Office before participating in any tryout for any school sport.

Student's Name: _____ ID#: _____

Emergency Contact Number: _____

Check the Sport(s) you will try out for this year:

Basketball _____
Cheerleading _____
Soccer _____
Softball _____
Step Team _____

Swimming _____
Track & Field _____
Cross Country _____
Outdoor _____
Indoor _____
Volleyball _____

Parental Permission & Emergency Authorization: THIS SECTION MUST BE SIGNED

I give my child permission to participate in the above-mentioned sport(s). I, the undersigned, also agree that participation in the above mentioned sport(s) has its risks, and I further agree that medical insurance coverage for my daughter on this sport(s) at Bishop Kearney High School will be provided by me. (The policy covering all students is an "excess policy".) I further agree that Bishop Kearney, its agents and employees, shall not be liable to me for any injury or damage resulting directly or indirectly from my child's participation in this sport(s). I also agree that I will not sue, arrest, attack or prosecute its agents and employees from all actions, claims and demands my child may have for any injury or damage.

Emergency Authorization: I hereby give my permission to the medical and/or coaching personnel selected by the school to order X-rays, routine tests and give treatment for, and to order injections and/or anesthesia and/or surgery for my child named above. This form may be photocopied for use out of school.

Signature of Parent and/or Guardian: _____

Date: _____

Name: _____ ID#: _____ Sex: _____ DOB: _____

EXPLAIN YES ANSWERS BELOW.

A yes answer to a question does not mean automatic disqualification from athletic activity.

	YES	NO
1. Have you ever been hospitalized?	_____	_____
2. Are you presently taking any medications or pills?	_____	_____
3. Do you have any allergies (medicine, bees, or other stinging insects)?	_____	_____
4. Have you ever had chest pain during or after exercise?	_____	_____
Have you ever had high blood pressure?	_____	_____
Have you ever been told you have a heart murmur?	_____	_____
5. Do you have any skin issues (itching, rashes, acne)?	_____	_____
6. Have you ever had a head injury?	_____	_____
7. Do you wear glasses, contacts, or protective eye wear?	_____	_____
8. Have you ever broken or had repeated swelling or other injuries of any bones or joints?	_____	_____
Body Part: _____		
9. Have you ever had any other medical problem (infectious mononucleosis, diabetes, asthma, etc.)?	_____	_____
10. Have you had a medical problem or injury since your last evaluation?	_____	_____
11. When was your last tetanus shot?	_____	_____
12. Other important medical information (Please explain below):		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Parent and/or Guardian Signature: _____ Date: _____

PHYSICIAN'S EXAMINATION:

This certifies that I have examined the above named student and she is in good health and is physically cleared to participate in all interscholastic sports without any restrictions.

PRINT NAME of PHYSICIAN: _____

PHYSICIAN'S STAMP

PHYSICIAN'S SIGNATURE: _____

Date of Examination: _____