

**Monsignor Scanlan High School
915 Hutchinson River Pkwy.
Bronx, NY 10465**

Office of the Athletic Director

Athletic Participation/Parental Consent/Physical Examination Form

This form must be filled out prior to trying out for any sport.

Form 1: For Athletic Director

ATHLETIC PARTICIPATION

For School Year _____

Team: _____
(To be filled in and signed by the student)

Male _____
Female _____

PRINT CLEARLY

Name: _____ Year: _____
(Last) (First)

Home Address: _____

City/Zip Code: _____

Date of Birth: _____

As a Lady Crusader/ Crusader I am aware of the following:

- I am responsible for maintaining a good academic standing in all my classes
- If I have a poor progress report /report card, it is my responsibility to attend tutoring sessions
- I am responsible for my uniform and I should return it as I received it at the end of the season
- I am responsible for maintaining a good discipline standing by following all school rules.

Student Signature: _____ Date: _____

Form 2 – Athletic Office

(To be completed and signed by parent/guardian)

I give permission for _____ to participate on the following team: _____

EMERGENCY PERMISSION FORM

(To be completed and signed by parent/guardian)

STUDENT'S NAME : _____ **GRADE** _____ **AGE** _____

I hereby give permission for my child to participate in the Msgr. Scanlan’s Interscholastic Athletic Program. This consent includes practice sessions and travel to and from Athletic contests. I also understand that injuries may occur during interscholastic competition and/or practice. In the event of an injury, you will be notified immediately. The School Nurse will be notified the following school day.

I understand and agree to my responsibility to supply any medication, with instructions, for your child that are prescribed for daily and/or emergency conditions.

Please list the student-athlete’s current and significant medical/health conditions:

Please list current medications/dosages prescribed by a medical doctor, including Bronchial inhalers for Bronchial Asthma

Please list any EMERGENCY medications prescribed by a medical doctor. Ex: Epi-pen

Please list any ALLERGIES to medications / food.

Does the student-athlete wear contact lenses and/or any type of joint/back brace?

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of Msgr. Scanlan to hospitalize, secure proper treatment, order injection and/or anesthesia and/or surgery for the student/athlete named above.

Daytime phone number (where to reach you in emergency) _____

Evening time phone number (where to reach you in emergency) _____

Parent/Guardian Name: _____

Date _____

I certify all the above information is correct _____

Parent/Guardian Signature

Form 3 – Medical Office

Student Name: _____

Date of birth: _____

Address: _____

Phone: _____

EMERGENCY NOTIFICATION:

With whom does the child reside and what is/ are his / her relationship with the student?

Daytime phone number: _____

Evening phone number: _____

Person to contact in an emergency if parents/guardians are unavailable:

Name: _____ Cell: _____

MEDICAL INFORMATION / HISTORY:

Physician: _____

Phone: _____

Dentist/Orthodontist: _____

Phone: _____

CHECK YES OR NO

Yes ___ No ___ Allergy to a medicine, food, plant, animal or insect

Yes ___ No ___ Do you have an Epi-Pen

Yes ___ No ___ Seizure Disorder

Yes ___ No ___ Special medication or Diet

Yes ___ No ___ Asthma

Yes ___ No ___ Contact Lenses

Yes ___ No ___ Diabetes

Yes ___ No ___ Heart Trouble

Yes ___ No ___ Bleeding Disorder

Yes ___ No ___ Dentures

Yes ___ No ___ Bonded Teeth

Explain any of the above: _____

Any serious illness? Yes ___ No ___ Date _____ Details: _____

Any serious injury? Yes ___ No ___ Date _____ Details: _____

Does the student-athlete have frequent: Check Yes or No

Eye Infections Yes ___ No ___ Respiratory Infections Yes ___ No ___

Ear Infections Yes ___ No ___ Urinary Tract Infections Yes ___ No ___

Throat Infections Yes ___ No ___ Vaginal Infections Yes ___ No ___

Does the student-athlete have: Check Yes or No

Heart Murmur Yes ___ No ___ Menstrual Problems Yes ___ No ___

Rheumatic Fever Yes ___ No ___ Hernia Yes ___ No ___

Back or Joint Pains Yes ___ No ___ Stomach/Intestinal Problems Yes ___ No ___

Explain any of the above: _____

Has the Student- Athlete had Chicken Pox? Yes ___ No ___ Date _____
Has the Student-Athlete had Mumps? Yes ___ No ___ Date _____
Has the Student-Athlete had any injuries in the last 3 years? _____

Explain: _____

Disease Assessment:

Yes ___ No ___ Asthma ___ Mild ___ Moderate ___ Severe ___ Exercise induced ___ Unclassified Onset Date: _____

Yes ___ No ___ Diabetes ___ Type I ___ Type II Onset Date: _____

Yes ___ No ___ Anaphylactic Reaction ___ Food ___ Insect ___ Latex ___ Other(Explain) Onset Date: _____

List Ages and Diagnosis for any checked yes:

Hospitalized and Surgical History:

Please list dates/ ages/ reasons for hospitalization and surgeries

Date / Age	Reason/ Diagnosis	Type of Surgery

Please indicate all CURRENT medications/ dosages/ treatments currently prescribed for student-athlete.

Name	Dosage	Frequency	Special Treatments

Please indicate any prescribed/ recommended use of joint/ back braces and/or prosthesis :

Please indicate any limitations/ precautions for student – athlete in full participation on a team:

I certify that I have on this date examined the above named student-athlete and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student-athlete to participate in physical, strenuous activities.

Signature of Physician: _____ Date: _____

License Number: _____

Address: _____

Parent Signature: _____ Date: _____