SPORTS RECHECK/PERMISSION/AWARENESS **Homeroom Teacher: _____ Room: _____**

Name: _____Grade _____ Date of Birth _____Sport _____

Medical History: SINCE YOUR LAST SPORTS PHYSICAL	*** ANSWER * YES**	**NO**
1. Any injuries required medical attentions?	_____	_____
2. Any illness lasting more than five (5) days?	_____	_____
3 Taking any medication or under physicians' care at this time?	_____	_____
4. Any feeling of faintness, dizziness or fatigue after heavy exertion?	_____	_____
5. Any surgery, fractures or dislocations?	_____	_____
6. Treated in a hospital or emergency room?	_____	_____
Medical History: IN GENERAL:		
1. Wear glasses or contact lenses?	_____	_____
2. Any known allergies?	_____	_____
3. Any chronic diseases?	_____	_____

If **YES** to any of the above, please describe (use back if needed): _____

_____

_____

PHONE NUMBER: Home _____

Work _____

To my knowledge, there is no medical reason that my son/ daughter cannot participate in interscholastic sports. We have read and understand all athletic training rules and regulations.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Student Date

NOTE: *** YES *** to **ANY** of these questions may require a written release from your physician.

RETURN TO HEALTH (NURSES) OFFICE