ALL SAINTS' EPISCOPAL DAY SCHOOL

Est. 1960

Sports Health Assessment

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE YOUR CHILD CAN PARTICIPATE IN SOCCER, CHEERLEADING, BASKETBALL, VOLLEYBALL, OR OTHER ATHLETICS.

Name: _____ DOB: _____

Address: _____

Person to Notify for Emergency: _____

Emergency Telephone Number: _____

Physician: _____ Telephone: _____

Yes	No	To be completed by student and parents (check yes or no.)
1.___	___	Is there a family history of heart problems or high blood pressure? (grandparents, parents, siblings)
		HAVE YOU EVER HAD OR DO YOU PRESENTLY HAVE . . . . .
2.___	___	Heart murmur, high blood pressure, extra heartbeats, heart abnormality?
3.___	___	The need for using medications? Current Medications:_____
4.___	___	Concussion or problem "passing out"?
5.___	___	Allergic to any medications? List:_____
6.___	___	Any illness, condition, or injury that is chronic or on going? List:_____
7.___	___	Hospitalization or surgery? Reason, date(s): _____
8.___	___	Dental appliance?
9.___	___	Contacts or glasses?
10.___	___	Need to stop while running around a ¼ mile track twice?
11.___	___	Congenital absence or loss of function of one organ (eye, ear…)?
12.___	___	Headaches (frequent)?
13.___	___	Asthma?
14.___	___	Convulsions (seizures)?_____Frequency:_____
15.___	___	Neck or spine injury?_____
16.___	___	Broken bones? _____
17.___	___	Sprains or dislocation?_____
18.___	___	Tetanus shot? (Date) _____

Permission for Child to Participate in Athletics at All Saints' Episcopal Day School

As the parent or legal guardian of _____, I give my consent for his/her participation in athletics. I agree that I will not hold All Saints' Episcopal Day School nor any employee of All Saints' Episcopal Day School responsible for any injury or damage to said child resulting from his/her participation in athletics. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history provided is accurate to the best of my knowledge.

Parent or Legal Guardian: _____ Date: _____