

**ALL SAINTS' EPISCOPAL
DAY  SCHOOL**

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: _____