SPORTS SCREENING--TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Name: _____ Date of Birth: _____ Date: _____

Grade: _____ Sport: _____ Level: _____

Have you ever passed out during or after exercise?	YES	NO
Have you ever had chest pain during or after exercise?	YES	NO
Have you ever had racing of your heart or skipped heartbeats?	YES	NO
Have you ever been told you have a heart murmur?	YES	NO
Has any family member or relative died of heart problems or of sudden death before the age of 50?	YES	NO
Have you had a severe viral infection (e.g. myocarditis or mononucleosis) within the last month?	YES	NO
Has a physician ever denied or restricted your participation in sports for any heart problem?	YES	NO

Please explain any "YES" answers: _____

_____

_____

A: The student as named above has my permission to receive a physical screening by the designated school health care provider.

B: The student has my permission to engage in all prescribed activities except as noted by me, the student's private health provider, or the schools designated health care provider.

C: The student's parent or guardian is responsible for notifying the team coach and school nurse should an injury or serious illness occur within the year in which the form is valid.

D: In the event I cannot be reached in an emergency, I hereby give my permission for the coach/nurse/teacher to contact Emergency Medical Services and the student to be transported to the nearest Emergency Room as deemed urgently medically necessary.

I have read and fully understand statements A, B, C & D. I understand that if I wish my students private provider to do the physical screening, I must have that provider complete this portion as well as the NYS School Health Examination form in their entirety and return the form to the school nurse.

I have answered all questions to the best of my ability.

Parent/Legal Guardian Signature: _____ Date: _____

PART E – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Date of last health appraisal: ___/___/___

Limitations: _____yes _____no

Sports Participation (check):

____ Approved _____ Referred to School Physician

Signed _____ Date _____/_____/_____

School Health Office

If referred to the School Physician (check):

_____ Requalified _____ Disqualified

Signed _____ Date _____/_____/_____

School Physician