

NORTH BRANFORD HIGH SCHOOL

PARENT'S PERMISSION FORM FOR ATHLETICS
2009 – 2010 SCHOOL YEAR

Athlete's Name: _____ Phone: _____
Parent's Name: _____ Phone: _____
Parent's Work Phone: () _____ or () _____

List the sports (Football, Soccer, VB, X-C, BB, etc.) that you are giving
Permission for you child to participate in: **Do NOT just put an "X"**

Fall: _____ Winter: _____ Spring: _____

LIST any conditions that a coach should be aware of: _____

Date of last TETANUS Shot: _____

IN CASE OF EMERGENCY, Please contact one of the people listed below if a
parent cannot be contacted/notified. **ALL** of the phone numbers listed below must
be filled in **BEFORE** your child will be allowed to try-out or practice for a team.

Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____

Hospital Preference : _____ Phone: _____
Physician's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____

I/We give permission for _____ (athlete's name) to
participate in organized high school athletics for the current school year, realizing
that such activity involves the potential for injury which is inherent in all sports.
I/We acknowledge that even with the best coaching, use of the most advanced
protective equipment and strict observance of rules, injuries can be so severe as to
result in total disability, paralysis, or even death.

In case of emergency and I/We cannot be contacted, I/We give my/our permission
for my/our child to receive medical attention.

Signature of Parent/Guardian: _____ **Date:** _____

(A xerox copy of this form will be carried by each coach to practice/contests)

North Branford Public Schools.....Pre-Participation Sports Physical, 2009 – 2010
 The front and back of this form as well as the emergency waiver must be completed

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education.

Please PRINT neatly and fill out completely or your child will not be able to compete until this is done

Name of Student (Last, First, Middle)		Birth Date	Sex
Address (Street)		Race/Ethnicity	
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other
Home Telephone Number	School	Grade	
Name of Parent/Guardian (Last, First, Middle)			
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*	

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

**Important: Complete Part I before your child is examined.
 Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
 (Explain all "yes" answers in the space provided below.)

- | Yes | No | |
|------------------------------|--------------------------|--|
| 1. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease? <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY) |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

To the Health Care Provider: Please complete and sign.

Student's Name _____ Birth Date _____ has had a complete history and physical exam on _____ Month/Day/Year

Findings for this student are as follows:

Screening/Test Results

Note: * Mandated Screening/Test under Connecticut State Law

* Height:		BMI:
* Weight:		* Postural:
* Blood Pressure:		<input type="checkbox"/> Normal
Pulse:		<input type="checkbox"/> Abnormal
* HCT/HGB:		Min. _____
Urinalysis:		Slight _____
* Gross dental:		Mod. _____
Lead (Date/Result)		Marked _____
		<input type="checkbox"/> Referral

Immunization Record

Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP	*	*	*	*		
DTP/Hib						
DTaP						
DT/Td						
OPV	*	*	*			
IPV	*	*	*			
MMR						
Measles	*	*				Booster for entry into K and 7th grade
Mumps	*					
Rubella	*					
HIB	*					Students under age 5
Hep B	*	*	*			Req. for entry into K and 7th grade.
Varicella	*					Students born 1/1/97 or later. Required for 7th grade entry.
PCV						Pneumococcal conjugate vaccine

TB and Other Test Results (Sickle Cell, etc.)
 TB: In high-risk group? Yes No

Test	Date	Results

* Chronic Disease Assessment:

Yes	No	Date of onset
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified		_____
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II		_____
<input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex		_____
<input type="checkbox"/> Seizure Disorder		_____
<input type="checkbox"/> Other: Please specify _____		_____

Other Vaccines (Specify)

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption
 Religious _____ Medical: Permanent _____ Temporary _____ Date _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

This student has the following problems which may adversely affect his or her educational experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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