

ADDRESS: 750 Maiden Lane, Rochester, NY 14615

MAILING ADDRESS: P.O. Box 300, N. Greece, NY 14515

TELEPHONE: 585.966.2255

WEB ADDRESS: www.grcece.k12.ny.us

STUDENT LEARNING IS THE GOAL

Athletic Permission and Medical Recertification

Complete

and return to

school

Student Name	Sport	High School Middle School
Grade School	Date of Birth	Sex: Male Female
Date:		
Parent Name	Home Phone	Work Phone
Address		
Emergency Contact (name and phone number)		
Physician's Name	Address	Phone
Dentist's Name	Address	Phone
Insurance Carrier	I.D.#	
Insurance Carrier(A Student Physical Exam(A Student Physical Exam	ical Exam form, dated within the last yea	or must be on file in the nurse's office)
Prior to the start of tryout practice sessions at the beginning of each season, a health history review for each athlete must be conducted. In the event of illness or injury requiring medical attention by a physician, students need to present a written release from a physician to be reinstated to physical education and/or interscholastics		
All "YES" answers must be explained (box on bottom right)		
 Have you had a medical illness or injury or a new diagnosis since your last sports physical? Have you ever been hospitalized overnight or had surgery? Are you currently taking any medication or pills (prescription or over the counter) or using an inhaler? Have you ever taken any supplements, vitamins, or recreational drugs to help you improve your performance? Do you have any allergies (for example: to pollen, medication food, stinging insects or seasonal allergies)? Have you ever had chest pain, dizziness or fainting during of after exercise? Has a physician ever denied or restricted your participation in sports for any heart problems? Has any family member or relative died of heart problems of sudden death before age 50? Have you had a severe viral infection (for example: myocardition or mononucclosis) within the last month? Do you have one kidney, one testicle or monocular vision? Do you have any current skin problems (for example: warts fungus or impetigo)? Have you ever had a head injury or concussion? Have you ever had heat cramps, heat exhaustion, or heat stroke? Do you cough, wheeze or have trouble breathing during of after exercise or have asthma or lung disease? Do you use any special protective or corrective equipment of devices that aren't usually used for your sport (for example: kne brace, foot orthotics, retainer on your teeth, hearing aid)? Have you ever had a problem with your ears or hearing? 	18. Have you broken or fracture joints, or been diagnosed with 19. Have you ever had a sprain any other problem with pair bones or joints that has kept 20. Have you experienced frequency 21. Do you lose weight regularly 22. Has there been an unexplase during the past six months? 23. Are you currently following reducing plan? 24. Have you ever tried to compare the part of th	red any bones or dislocated any has stress fracture? , strain or swelling after injury or or swelling in muscles, tendons, you from participating in sports? ent abdominal discomfort? to meet weight for your sport? ined weight loss or weight gain or swelling in sports? g any particular diet or weight or weight or weight by vomiting, using or sing disorders? ge
Parent/Guardian – Please Read Carefully and Sign I have carefully read and understand the questions. To the best from athletic participation. My signature below constitutes my District does not assume responsibility for lost or broken corre constitutes my permission for my child to receive medical eva come from either my child's physician or another physician or discretion. I guarantee payment for any medical treatment pro Parent/Guardian Signature:	permission for my child to participate in the active lenses or orthodontic devices. In the evolution and necessary treatment to ensure his medical facility as deemed appropriate by the wided for my child under this authorization.	above named sport. I understand that the ent of an emergency, my signature below /her health and safety. Such treatment may
For Office Use Only Date of last physical exam This certifies in the sport indicated above. Date: Signature This certificate is void if pupil is absent for five or more consecutive description.	re: Signature of School Physician or Nur.	56

GCSD-12 Copies to: White: School Nurse Yellow: Assistant Principal for Athletics Pink: Coach rev 9/15