REQUIRED TO TRY OUT FOR ALL SPORTS

Dear Parent/Guardian,

This form should be dated after June 1st, 2018 and completed on both sides and given to the School Nurse before participating in any tryout for any school sport. It will remain on file for the 2018/2019 season.

Students Name ____________________________ ID # _____________
Emergency Contact Number ________________________
Check the Sport(s) you will try out for this year:

Baseball ___
Basketball ___
Bowling ___
Cross Country ___
Dance___
Golf ___
Handball___
Lacrosse___
Soccer ___
Softball ___
Swimming ___
Step___
Track & Field___
Tennis___
Volleyball___
Weight Room___

Parental Permission and Emergency Authorization: This section *must* be signed.

I give my child permission to participate in the above mentioned sport(s). I, the undersigned, also agree that participation in the above mentioned sport(s) has its risks and I further agree that medical insurance coverage for my son/daughter on this sport(s) at Archbishop Molloy High School will be provided by me. (The policy covering all students is an "excess policy.") I further agree that Archbishop Molloy, its agents, and employees shall not be liable to me for any injury or damage resulting directly or indirectly from my child's participation in this/these sport(s). I also agree that I will not sue, arrest, attach or prosecute its agents and employees from all actions, claims, and demands my child may have for any injury or damage.

Emergency Authorization: I hereby give my permission to the medical and or coaching personnel selected by the school to order x-rays, routine tests, and treatment for my child in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child whose name is above. This form may be photocopied for use out of school.

Signature of Parent or Guardian ______________________________ Date________

Nurse's Office
83-53 Manton Street, Briarwood, NY 11435 | Phone:718-441-2100 ext. 123 | www.molloyhs.org

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ARCHBISHOP
MOLLOY
HIGH SCHOOL
Not for school but for life

SPORTS PHYSICAL

NAME___________________________________ STUDENT ID # ________ SEX_____ D.O.B._______

EXPLAIN YES ANSWERS BELOW. **A yes answer to a question does not mean automatic disqualification from athletic activity.**	**YES**	**NO**
1. Have you ever been hospitalized?	___	___
2. Are you presently taking any medications or pills?	___	___
3. Do you have any allergies (medicine, bees, or other stinging insects)?	___	___
4. Have you ever passed out during or after exercises?	___	___
Have you ever been dizzy during or after exercise?	___	___
Have you ever had chest pain during or after exercise?	___	___
Do you tire more quickly then your friends during exercise?	___	___
Have you ever had high blood pressure?	___	___
Have you ever been told you have a heart murmur?	___	___
Have you ever had racing of your heart or skipped heartbeats?	___	___
5. **Do you have any skin problems (itching, rashes, acne)?**	___	___
6. **Have you ever had a head injury?**	___	___
Have you ever been knocked out or unconscious?	___	___
Have you ever had a seizure?	___	___
Have you ever had a stinger, burner or pinched nerve?	___	___
7. **Have you ever had heat or muscle cramps?**	___	___
Have you ever been dizzy or passed out in the heat?	___	___
8. **Do you have trouble breathing or do you cough during or after activity?**	___	___
9. **Do you use any special equipment (pads, braces, mouth guard or goggles, etc.)?**	___	___
10. **Have you had any problems with your eyes or vision?**	___	___
Do you wear glasses or contacts or protective eyewear?	___	___
11. **Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?**	___	___
Body Part____		
12. **Have you had any other medical problem (infectious mononucleosis, Diabetes, asthma, etc.)?**	___	___
13. **Have you had a medical problem or injury since your last evaluation?**	___	___

14. **When was your last tetanus shot?______________________________________**
15. **When was you first menstrual period?__________________________________**
What was your longest time between your periods?________________________

EXPLAIN ALL "YES" ANWSERS____
____
____
____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Parent/Guardian Signature____________________________________ Date___________________

Physicians Examination: Should be dated after June 1st, 2018

This certifies that I have examined the above named student and he/she is in good health and is physically cleared to work and participate in all interscholastic sports without any restrictions during the school year 2018/2019.

Print Name of Physician _________________________________
Physician's Signature ___________________________________

Physician's Stamp _________________ _____________________
Date of Examination _____________________________________

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