

## NORTHSTAR SPORTS PARTICIPATION PARENTAL CONSENT/PHYSICAL FORM

## STUDENT INFORMATION/HEALTH HISTORY

(TO BE COMPLETED BY PARENT/GUARDIAN)

Student's Name			Date of Birth/ / Gra	de							
(Last)		(First)	(MI)								
□Male □ Female											
Student's Home Address											
Parent/Guardian Name(s)											
Parent/Guardian Primary Phone Number				ell □V	/ork						
Parent/Guardian Secondary Phone Number											
·											
The following portion must be completed and	l signe	d prior t	to the physical examination, for review by exc	amininç	3						
practitioner.											
Check box if applicable:											
□Student wears glasses or contact lenses											
Student has allergies to medicine, food, and/or insects. List here:											
•			nal supplements)								
Date of student's last tetanus booster											
Answer YES or NO, Explain "yes" answers below:	YES	NO		YES	NO						
1. Has a doctor ever denied or restricted the			11. Has the student ever had a head injury or								
student's participation in sports for any			concussion? *If yes, include date of last injury in								
reason? 2. Is the student being treated for a chronic			explanation below.  12. Has the student ever complained of	$\vdash$							
medical condition? (asthma, diabetes,			headaches during or after exercise?								
anemia, seizures, etc.)			J								
3. Has the student had previous surgeries?			13. Has the student ever been unable to move								
			his/her arms or legs after being hit or falling?	<u> </u>							
4. Has the student ever passed out DURING or AFTER exercise?			14. When exercising in heat, does the student have severe muscle cramps or become ill?								
Has the student ever had discomfort, pain, or			15. Does the student have a blood disorder or	$\vdash_{\Box}$							
pressure in chest during exercise?			bleeding problem?								
6. Is there a family history of heart problems?			16. Does the student have groin pain or a painful								
			bulge or hernia in the groin area?	<u> </u>							
7. Has the student had any previous injuries			17. Does the student have any rashes, pressure								
(sprain, muscle or ligament tear, etc.) that caused him/her to miss a practice or game?			sores, or other skin problems?								
Has the student ever had any broken or			18. Has the student had any problems with								
fractured bones or dislocated joints?			his/her eyes or vision, and/or ears or hearing?								
9. Does the student cough, wheeze, or have			19. Do you or the student worry about his/her								
difficulty breathing during or after exercise?			weight?	<u> </u>							
10. Does the student have a history of juvenile arthritis or connective tissue disease?			20. Do you/the student have any concerns that you/he/she would like to discuss with a doctor?								
arthritis or connective tissue disease?   you/he/she would like to discuss with a doctor?    Explain all "YES" answers with the number of the question:											
#>>											
#>>											
#>>											
#>>											



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In the event of an emergency, I hereby give permission for the coaches and staff of Northstar to obtain emergency medical treatment for the student named above. In the event that I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of Northstar to hospitalize and/or secure appropriate medical treatment for the above named student. I am aware that participating in sports will involve travel with the team to and from contests and practices. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for the above named student to participate in the sport and travel with the team.

PARE	ENT/LEGAL GUARDIAN'S SIGNATUR		Date			
	SICAL EXAMINATION BE COMPLETED BY EXAMINING PRACE	CTITIONER)				
Student's Name						_ Date of Birth/ / Age
	(	Last)		(First)		(MI)
	Height Weight_			Vision: R: 20/	L: 20/	Corrected ☐ YES ☐ NO
	B/P Resting	Pulse		Hearing: R:	L:	Hearing Aids 🔲 R 🔲 L
MED	DICAL	NORMAL	AB	NORMAL:		
Eyes	/ears/nose/throat					
Lym	ph nodes					
Hea	rt					
Puls	es					
Lunç						
	omen					
Skin						
	itourinary (males only)					
	rologic					
MUS	SCULOSKELETAL	NORMAL	AB	NORMAL:		
Nec	k					
Bacl	<					
	ulder/arm					
Elbo	w/forearm					
Wris	t/hand/fingers					
Hip/	thigh					
Kne	e					
Leg/	ankle					
Foot	/toes					
Fund	ction	_			_	
Eme	rgency medications required on-s	ite:	ıler	☐ Epinephrine ☐	] Glucagor	Other:
COMMENTS:						



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I certify that on this date I examined this student and reviewed the medical history furnished to me. Based on my examination and review of this student's medical history this student is physically able to participate in athletic and competitive sports activities. I clear this student to participate in athletic and competitive sports activities for one year.

Examining Practitioner's Signature	Date of Examination:
Address:	Phone Number:
NOTE: THIS FORM MUST BE COMPLETELY FILLED OUT AND FILED WITH N ACTIVITIES.	ORTHSTAR PRIOR TO THE STUDENT'S PARTICIPATION IN SPORTS