Clinton Public School

10 School Street Clinton, NJ 08809 Phone 908-735-7283 Fax 908-730-7468

SPORTS PERMISSION FORM

Student_____ Grade/Teacher_____ Date of Birth_____

Parent/Guardian Names_____

Address_____Home Phone_____

Mother's Cell Phone _____ Father's Cell Phone _____

Work Phone: Mother _____ Business name and address _____

Work Phone: Father _____ _____ Business name and address _____

Alternate contact_____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____
Physician_____Phone_____
Dentist_____Phone_____

PARENT/GUARDIAN PERMISSION TO PLAY A SCHOOL SPORT

Understand my child, _____, desires to participate in _____ at Clinton Public School.
(Name of student) (Name of sport)

Realizing that such activity involves the potential for injury, which is inherent in all sports, I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis, or even death. I have read and understand this warning and I hereby give permission for my son/daughter to play _____(Name of Sport).

Parent/Guardian Signature _____ Date _____

AUTHORIZATION FOR EMERGENCY TREATMENT

In case of an emergency or serious illness, I request that I/we be contacted. I hereby give permission for emergency medical treatment that will include, but not limited to, initial diagnostic x-rays and other such procedures as the physician may see as necessary for the preservation of health.

Parent/Guardian Signature_____ Date_____

SPORTS HEALTH HISTORY

Please answer each question by checking yes or no. **If the answer to any question is yes, please explain on the reverse side of this form.**	YES	NO
1. Does the student have any **allergies to medications, foods or other things?**		
2. Does the student have any **allergies to bee stings?**		
3. Does the student have a history of asthma?		
4. Has the student ever had surgery? If yes, please list the surgery and date.		
5. Has the student ever been hospitalized for any other reason? If yes, please list, including diagnosis and dates.		
6. Has the student ever broken a bone? If yes, please list fracture and date.		
7. Has the student ever suffered any dislocations or sprains?		
8. Has the student ever been advised by a physician NOT to participate in a sport?		
9. Has the student ever sustained a concussion or experienced a loss of consciousness after an injury?		
10. Has the student experienced any frequent chest pain?		
11. Has the student experienced any rapid heartbeats or palpitations?		
12. Has the student experienced any frequent fatigue or undue tiredness?		
13. Has the student ever fainted during or after exercise?		
14. Has anyone in the student's family ever died a sudden death?		
15. Does the student take any medication on a regular basis? **If yes, please list the names of the medications, dosages and times they are taken.**		
16. Is the student currently under the care of a physician for any problem?		
17. Does the student have any chronic medical problems?		
18. Is there any other aspect of the student's medical history that has not been noted?		

I certify that the above health history is accurate:
Parent/Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF SPORTS-RELATED CONCUSSION, SUDDEN CARDIAC DEATH AND OPIOD USE AND MISUSE INFORMATION

I have read and understand the information provided regarding the risk of sports-related concussion and sudden cardiac death for student athletes and about opioid use and misuse in students and student athletes.

Parent/Guardian Signature:_____ Date:_____

Student Signature:_____ **Date:** _____