School Attending _____

Rochester City School District
Interscholastic Athletics
Medical Eligibility Certification

Student Name_____ Grade:_____ Birthdate:_____ Age:_____

Telephone No(s) Home_____ Gender

Name of Parent/Guardian_____ Cell_____ M F

Emer_____ (circle one)

Address/Zip_____ Sport:_____

_____

Date Entered Ninth (9th) Grade:_____ Modified_____ J.V._____ Varsity_____

Part I Injury clearance for participation: must be signed by parent/guardian and student prior to medical clearance by the nurse:

This is to certify that _____has not had an injury or medical problem that will prevent
Student Name
him/her from participation in the sport specified above.

_____ _____ _____ _____

Parent/Guardian Signature | Date | Student Signature | Date

Part II (To be completed by the parent prior to the student's interview with the nurse.)

Prior to the start of tryout practice sessions at the beginning of each season, a health history review for each athlete must be conducted.

Name of Physician/Health Center_____ Date of last exam _____

Please answer each question.

	YES	NO
1. Have you been to an emergency room or seen a doctor for illness, injury, or abnormal lab test within the past year?		
2. Have you every had an operation?		
If yes, list_____		
3. Have you been hospitalized overnight for any reason?		
4. Have you ever had any of the following:		
Head injury?.....		
Fainting spells or loss of consciousness?.....		
Convulsions (seizures)?.....		
5. Have you had injury to joints, muscles, or bones within the past year? (ex. Severe sprain, fracture, dislocation)		
If yes, are there any after effects?.....		
6. Do you have pain or problems with your shoulder?		
Arm?.....		
Elbow?.....		
Wrist?.....		
Back?.....		
Hips?.....		
Knee?.....		
Ankle?.....		
7. Do you have problems with:		
Eyes or vision?.....		
Ears or hearing?.....		
8. Do you have absence or loss of function of paired organ? (eye, ear, kidney or testicle)		
9. Do you have any:		
Lumps?.....		
Sores?.....		
Infected areas?.....		

	YES	NO
10. Are you currently taking any medication?		
If yes, list_____		
11. Have you had a recent illness such as:		
Infectious mononucleosis?.....		
Bladder infection?.....		
Skin disease?.....		
Pneumonia?.....		
Other?.....		
12. Have you had symptoms or problems as:		
Dizziness.....		
Severe headache?.....		
Chest pain?.....		
Wheezing?.....		
Shortness of breath?.....		
Abdominal pain?.....		
Burning on urination?.....		
Excessive bruising?.....		
Adverse reaction from heat?.....		
Prolonged bleeding from small cut?.....		
Adverse reaction to exercise?.....		
High blood pressure?.....		
Allergies?.....		
Asthma?.....		
Heart trouble?.....		
Diabetes (sugar)?.....		
Hernia?.....		
Scoliosis?.....		
Sickle Cell Disease?.....		
Emotional disorder?.....		
Other?.....		
13. Have you seen a doctor for any of the above?		
14. Is there anything else we should know about your health?		
15. Is there a history of unexplained death in your family?		
If yes, relationship_____		

Part III (To be completed by nurse)

Date of nurse interview _____

Date of last approved physical_____

Restrictions include: (circle) None or _____

This certifies that the above student is qualified to participate in the sport specified above.

copies: White - School Nurse
Yellow - Athletic Director
Pink - Coach

School Nurse_____ Date _____

Athletic Director_____ Date _____