Southtowns Catholic School
Sports Candidates Questionnaire

THIS FORM MUST BE COMPLETED AND RETURNED
TO THE HEALTH OFFICE AS SOON AS POSSIBLE

Name ____________________ Medical Coverage Y N
Birth Date ______________ Name of Insurance Company
Age ________ ____________________

Has your child ever had: (please check)

	Yes	No		Yes	No
Allergies/Hay Fever	☐	☐	Elevated Blood Pressure	☐	☐
Bee Sting Allergy	☐	☐	Headaches	☐	☐
Asthma	☐	☐	Head Injury/Concussion	☐	☐
Amemia	☐	☐	Heart Problems/Murmur-Chest Pain	☐	☐
Arthritis	☐	☐	Nose Bleeds/Frequent Severe	☐	☐
Bladder/Kidney Problem or Injury	☐	☐	Ankle Injury	☐	☐
Convulsions/Seizures	☐	☐	Fracture-Dislocation Bones/Joints	☐	☐
Fainting Spells	☐	☐	Knee Pain/Injury	☐	☐
Diabetes	☐	☐	Nose Fracture	☐	☐
Ear Problems/Hearing Loss	☐	☐	Rheumatic Fever	☐	☐
Eye Problems/Vision Loss	☐	☐	Stomach Ulcer	☐	☐
Injury to the Spleen	☐	☐	Joint Strain/Ligament Tear/Muscle Pull	☐	☐
Wears Contacts/Glasses	☐	☐	Neck Injury	☐	☐
(Circle which one)			Back Pain/Injury	☐	☐

	Yes	No
Is your child missing any paired organs and/or transplants? (Example: eyes, ears,testicles, lungs, kidneys)	☐	☐
Has your child ever had an illness within the past year since last physical requiring medical attention, which may hinder sports participation? (Example: Diabetes, Hyperactivity, surgery)	☐	☐
Has your child taken medication in the past year?	☐	☐
Is your child taking any medication now?	☐	☐
Is your child under a Physican's care now?	☐	☐
Has your child ever fainted during exercise?	☐	☐
Has your child had a surgical operation? (Give dates and type of operation below)	☐	☐
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?	☐	☐

If you have checked YES to any of the above questions, please explain why in the space provided:

____

____

____

Parental Permission

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named on the front part of this form. The answers are correct as of this date and my son/daughter has my permission to participate.

Parent / Guardian Signatures

Date ______________ ______________________

____

Southtowns Catholic School of Saint John Paul II Parish
2052 Lakeview Road
Lake View, New York 14085

FOR OFFICE USE ONLY
☐ Sports Fee Paid
Uniform # Issued ______
☐ Uniform Returned

SPORTS - EMERGENCY INFORMATION & PARENTAL PERMISSION

Please answer ALL the following questions to help provide the best possible care for your child in case of injury while participating in interscholastic activities at Southtowns Catholic School. Include family physician and relative or friend who could be contacted when parents are not available.

Your son/daughter will be expected to attend all scheduled practices and games. I understand that I am responsible for transportation to and from practices and games. I understand that my son/daughter is responsible for all equipment and uniforms issued. If any of the equipment or uniforms issued are not returned in proper condition, I am liable for their replacement value.

I understand if my child is unable to participate in Physical Education class or is absent from school, he/she will be unable to participate in any sports activities.

Student Name: ______________________________ Grade: ________

Has my permission to participate in: ______________________________

for the ________________ school year. Home Phone: ________________

Mother's Name: ________________________ Cell #: ________________

Work # ________________

Father's Name: ________________________ Cell #: ________________

Work # ________________

Person to call in case of emergency:

Name: ________________________ Home # ________________

Relationship to Child ________________________ Cell # ________________

Child's Physican: ______________________________

Office Phone # ________________________

Authorization:

In case of emergency, if I cannot be reached, I authorize ________________________ (Child's Name)
to receive emergency treatment including treatment by a doctor other than our family physician.

Date: ________________ ______________________________

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Parent or Guardian Signature

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2052 Lakeview Road
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PARENT CONSENT & HEALTH OFFICE UPDATE QUESTIONNAIRE FORM

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Prior to the start of tryout seasons or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

Name: ______________________ Grade: ______ Birth Date: __________

Address: ______________________ Phone # ______________

Gender: M F Sport: ______________

Date of last approved sports physical: ______________ by ______________

Since your child's last sport physical, has he/she had any of the following?

INTERVAL MEDICAL HISTORY

Any injuries/ illness lasting 5 or more days requiring medical attention?	YES	NO
Taking any medicine or under a physician's care at this time?	YES	NO
Any feeling of faintness, dizziness, fatigue after heavy exertion?	YES	NO
Any surgery, broken bones, concussions or treated in an ER?	YES	NO
Any known allergies or chronic disease?	YES	NO
Any change in wearing glasses or contact lenses?	YES	NO

If "yes" to any of the above, please explain:

____

PARENTS MUST NOTIFY SCHOOL OF ANY CHANGES IN CHILD'S MEDICAL STATUS.
We have carefully read, understand and agree to abide by the rules and regulations set by Southtowns Catholic School. To the best of our knowledge, there is no physical condition that would exclude the above named athlete from participation.

Parent/Guardian Signature: ______________________ Date: __________

Parent/Guardian Signature: ______________________ Date: __________

The above named student is physically qualified to participate in: ______________

Restrictions: ______________________

School Nurse: ______________________ Date: __________

Phone: 716-627-5011 www.southtownscatholic.org Fax: 716-627-5335