

**Halifax Academy
SPORTS PHYSICAL**

Name: _____ D.O.B. _____ Grade: _____
 Address: _____
 Emergency contact: _____ Phone: _____
 Physician: _____ Phone: _____

HISTORY TO BE COMPLETED BY STUDENT WITH ASSISTANCE OF GUARDIAN

(Please check one)

	YES	NO
Did your grandparents, parents, brothers, or sisters under the age of 50 have heart problems or high blood pressure?	_____	_____
Have you EVER HAD or do you PRESENTLY HAVE:		
1. Heart murmur, high blood pressure, extra heart beats or a heart Abnormality?	_____	_____
2. The need for medication? Name: _____	_____	_____
3. Concussion or problems with "passing out"?	_____	_____
4. Medicine allergy? Name: _____	_____	_____
5. Any illness, condition, or injury that lasted longer than a week?	_____	_____
6. Hospitalization or surgery? Why? _____	_____	_____
7. Dental appliance? _____	_____	_____
8. Contacts or glasses? _____	_____	_____
9. To stop while running around $\frac{1}{4}$ mile track twice?	_____	_____
10. An illness or injury that caused you to miss a game or practice?	_____	_____
11. Congenital absence or loss of function of one organ (eye, ear, kidney, etc.)?	_____	_____
12. Headaches (frequent) ?	_____	_____
13. Asthma?	_____	_____
14. Convulsions (seizures) ? How many? _____	_____	_____
15. Neck or spine injury? _____	_____	_____
16. Broken bones? _____	_____	_____
17. Sprains or dislocations? _____	_____	_____
18. Tetanus shot (within last 10 years) ? Date: _____	_____	_____
19. FEMALES: Have you had a period in the last 6 months? How many? _____	_____	_____
20. FEMALES: Do menstrual cramps keep you from your regular activities?	_____	_____

MEDICAL EXAMINATION

Name: _____ Age: _____
 Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____
 Heart: _____ Vision: (R) _____ (L) _____
 Lungs: _____
 Abdomen: _____ Cardiovascular Murmur: _____
 Musculoskeletal: _____ Skin: _____
 Genitalin: _____
 Dental Status: Braces: _____ False Teeth: _____
 Urinalysis: Protein: _____ Sugar: _____ Cells: _____
 General Comments or Recommendation: _____

I certify that I have on this date examined this student and find him/her physically able to compete in the circled activities as follows: football, volleyball, basketball, swimming, baseball, softball, golf, cheerleading, soccer,

Other: _____ Exam date: _____
 Signed: _____ M.D. Address: _____ Phone: _____

Halifax Academy Pre-Participation Health and Permission Form

1. This form, when completed and signed, gives the student named below your permission to practice, play and travel in Halifax Athletic Council - approved events. Other guidelines for participation are as follows:
 - A. Parents of Junior Varsity athletes will assume full responsibility for transportation of their child to and from the games.
 - B. It is understood that neither the Halifax Academy Athletic Council nor Halifax Academy, Inc., will assume any responsibility should an accident occur.
 - C. The undersigned agrees to be responsible for the return of all athletic equipment issued by Halifax Academy to the student below.
 - D. The undersigned understands that because of the large number of students wanting to participate in athletics that it may be necessary to make cuts before the season starts to limit the number of players on teams. Last year's participation in a sport in no way guarantees an athlete a place on this year's team. Coaches will use their best judgment in the selection process.
 - E. Eligibility Requirements: All students must pass five (5) subjects in the previous semester to be eligible to participate in the semester. This applies to all athletic teams.
 - F. Attendance: In order to attend practice or play on game day, attendance in school is a must. (3 class minimum).

2. **INSURANCE** - All students must have accident insurance before participation is allowed.

Insurance Company: _____

Policy Number: _____

Name of Insured: _____

3. **Permission Statement:**

To: Head Coach, Athletic Director and Headmaster,

As a parent or guardian of _____, I give my consent for him/her to participate in the sports program(s) listed below. I also give my consent for the evaluation for participation. I do not hold the school responsible in any way whatsoever. I also grant permission for treatment deemed necessary for a condition arising during the participation in these programs - including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that all medical history on the preceding page is accurate to the best of my knowledge. I have also read and understand the eligibility rules printed on this form.

Circle the sports program for which you give permission: Football Volleyball Basketball
Swimming Golf Baseball Softball Soccer Cheerleading

Other: _____

Signed

Date