

**Rochester City / School District
Interscholastic Athletics
Medical Eligibility Certification**

Student Name: _____ Grade: _____ Birthdate: _____ Age: _____
 Name of Parent: _____ Telephone Nos.: _____
 or Guardian _____ Home: _____ M Sex F
 Address and zip: _____ Business: _____ (circle one)
 Emergency: _____
 Date Entered Ninth (9th) Grade: _____ Sport: _____
 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 him/her from participation in the sport specified above.

Student's Name

 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		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?			10. Are you currently taking any medication?		
2. Have you ever had an operation?			If yes, list _____		
If yes, list			11. Have you had a recent illness such as:		
3. Have you been hospitalized overnight for any reason?			Infectious mononucleosis?		
4. Have you ever had any of the following:			Bladder infection?		
Head injury? (concussion/fracture)			Skin disease?		
Fainting spells or loss of consciousness?			Pneumonia?		
Convulsions? (seizures)			Other?		
5. Have you had injury to joints, muscles, or bones within the past year?			12. Have you had symptoms or problems such as		
(ex: severe sprain, fracture, dislocation)			Dizziness?		
If yes, are there any after effects?			Severe headache?		
6. Do you have pain or problems with your shoulder?			Chest pain?		
Arm?			Wheezing?		
Elbow?			Shortness of breath?		
Wrist?			Abdominal pain?		
Back?			Burning on urination?		
Hips?			Excessive bruising?		
Knee?			Prolonged bleeding from small cut?		
Ankle?			Adverse reaction from heat?		
7. Do you have problems with			Adverse reaction to exercise?		
Eyes or vision?			High blood pressure?		
Ears or hearing?			Allergies?		
8. Do you have absence or loss of function of paired organ?			Asthma?		
(eye, ear, kidney or testicle)			Heart trouble?		
9. Do you have any			Diabetes (sugar)?		
Lumps?			Hernia?		
Sores?			Scoliosis?		
Infected areas?			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 sudden unexplained death in your family?		
			If yes, relationship _____		

Part III (To be completed by nurse)

Date of last approved physical _____ Date of nurse interview _____

Restrictions include: (circle) None or _____

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

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