

**SCHOOL SPORTS CONSENT FORM
DEPOSIT HIGH SCHOOL**

To be completed by parent/ guardian BEFORE the sports physical

A. Name: _____ Grade: _____ Age: _____ Sex: _____

Sports-JV/Varsity, Modified: _____

Parent/Guardian- name/address: _____

Home Phone: _____ Work Phone: _____

1. INJURIES(check any from past/present and state date)

- | | | |
|-------------------|-------------------------|-------------------------|
| -----Head or neck | -----Leg/foot | -----Broken Bones |
| -----Back | -----Joint Dislocations | -----Concussion |
| -----Arm/hand | -----Sprains/Strains | -----Any other injuries |

2. MEDICAL PROBLEMS (check any from past/present)

- | | | |
|-------------------------------------|--------------------------|------------------------------|
| -----Head, eyes, ears, nose, throat | -----Hernia/rupture | -----Loss of vision/hearing |
| -----Lungs-Asthma | -----Skin rashes | -----Hepatitis |
| -----Heart murmur/other | -----Mononucleosis | -----Loss of testicle/kidney |
| -----High Blood pressure | -----Anemia | -----Sickle Cell Anemia |
| -----Diabetes | -----Seizure/Convulsions | -----Easy Bleeding |
| -----Surgeries _____ | -----Allergies _____ | -----Eyeglasses/Contacts |
| | | -----Shatterproof lenses? |

-----Hospitalizations _____

-----Medications (please list all medications presently taking) _____

3. Family History of medically unexplained or heart related sudden death under the age of fifty?

B. Signature of parent or guardian is required for participation.

I hereby state that the above information is accurate and grant permission for the above named student to be examined by the school physician before participating in any organized school program. I understand that this medical information will become part of my child's school health record, and will be available for review by authorized school personnel.

Parent/Guardian Signature _____ Date _____
