

BROOKLYN FRIENDS SCHOOL

Health Form Supplement for Athletic Participation, 2011-12, for Students in Grades 5-12 only

Part III: To be completed/signed by parent/guardian and student/athlete - Due Aug. 15

Student Name _____ Gender _____ Date of Birth ___/___/___
LAST FIRST MIDDLE Grade in Sept '11 _____ mo. _____ day _____ year _____

Parent/Guardian Name _____
 E-mail _____

Parent/Guardian Phone Numbers:
 Home _____
 Cell _____
 Work _____

Parent/Guardian Name _____
 E-mail _____

Parent/Guardian Phone Numbers:
 Home _____
 Cell _____
 Work _____

Have you completed Parts I and II of the BFS Health Form? YES NO
Emergency Contact in the event BFS is unable to reach parent(s):
 Name: _____
 Phone: _____ Relationship: _____

Student's Physician (Name & Phone): _____
 Student's Dentist (Name & Phone): _____
 Medical Insurance Co. _____ Policy # _____
 Policy Holder's Name _____ Relationship _____

EMERGENCY CARE AUTHORIZATION: I give my permission for the school to administer first aid to my child as needed. I give permission for the school to contact my child's physician for medical instructions. In the event that I cannot be reached and emergency hospital care/treatment is needed, I give my permission for my child to be taken to the nearest hospital and given the necessary care.

X PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

Athletic Participation Health Screening; This section must be filled out completely. Thank you.

	Yes	No	Explain (attach extra page if needed)
Has student ever had an illness that:			
Required a hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>	
Caused you to miss 3 days of practice or a competition?	<input type="checkbox"/>	<input type="checkbox"/>	
Required an operation?	<input type="checkbox"/>	<input type="checkbox"/>	
Is related to allergies? (i.e. hay fever, hives, asthma, insect stings)	<input type="checkbox"/>	<input type="checkbox"/>	
Is chronic? (i.e.. asthma, diabetes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Has student ever had an injury that:			
Required you to see a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
Required you to go to an emergency room?	<input type="checkbox"/>	<input type="checkbox"/>	
Required a hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>	
Required x-rays or an operation?	<input type="checkbox"/>	<input type="checkbox"/>	
Caused you to miss 3 days of practice or competition?	<input type="checkbox"/>	<input type="checkbox"/>	
Has student ever:			
Been dizzy or passed out during or after exercise or participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>	
Been unconscious, had a concussion, or seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a heart murmur, high blood pressure, or a heart abnormality?	<input type="checkbox"/>	<input type="checkbox"/>	
Does student:			
Wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>	
Wear bridges, braces, or a dental plate?	<input type="checkbox"/>	<input type="checkbox"/>	
Have any current physical complaints (i.e. back, neck or joint pain)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is student:			
Missing a kidney?	<input type="checkbox"/>	<input type="checkbox"/>	
Able to run without stopping?	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Currently taking any medications, including inhalers?	<input type="checkbox"/>	<input type="checkbox"/>	

List all medications student is presently taking and the condition for which medication is ordered (attach extra page if needed):

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.
X Parent Signature: _____ **Date:** _____
X Athlete Signature: _____ **Date:** _____