

# BYFL ATHLETIC PARTICIPATION FORM

## CHILD INFORMATION

NAME:		DATE:	TEAM:	
ADDRESS:				
CITY:		STATE:	ZIP:	
SCHOOL:		AGE:	BIRTHDATE:	
SEX: <input type="checkbox"/> M <input type="checkbox"/> F		SPORT:	DOCTOR'S NAME:	DOCTOR'S PHONE:
HEALTH INSURANCE CARRIER:			POLICY NUMBER:	

## HEALTH HISTORY

HAS THIS STUDENT HAD:			IS THERE ANY HISTORY OF:		
YES	NO		YES	NO	
		Chronic or recurrent illness			Injuries requiring physician treatment
		Illness lasting over 1 week			Neck or back injury
		Hospitalizations			Knee Injury
		Surgery			Shoulder or elbow injury
		Missing organs			Ankle Injury
		Allergies (medicine, insect, food)			Other serious joint injury
		Problems with heart or blood pressure			Broken bones (fractures)
		Chest pain			
		Severe shortness of breath			
		Dizziness or fainting with exercise			
		Fainting, bad headaches or convulsions			
		Concussion or loss of consciousness			
		Heat exhaustion, heatstroke or other heat related problems			
<b>DOES THIS STUDENT:</b>					
		Wear eyeglasses or contacts			
		Wear dental bridge, braces or plates			
		Take any medications			

Please list any medications being taken:

### Parent's/Guardian's Acknowledgment:

I have reviewed and agree with the above information. I also understand that this examination is primarily for sports participation screening. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, accident or illness.

Print name of Parent or Guardian:		Signature of Parent or Guardian:	
Address: (if different from above)		Phone:	Date:

**GENERAL EXAMINATION (to be completed by the physician)**

	Normal	Abnormal (Describe)	
Eyes, Ears, Nose and Throat			Pulse: _____ BP: _____ Height: _____ Weight: _____ Visual Activity: R: _____ L: _____
Skin			
Lungs			
Heart			
Abdomen			
Date of last tetanus shot:			
List any medications currently receiving:			
Please detail any restrictions or limitations that should be followed during the course of any football or cheerleading activity:			
Allergies if any:			

<b>Recommendations:</b>	
<input type="checkbox"/>	Unlimited Participation
<input type="checkbox"/>	Clearance withheld pending further evaluation (Comment)
<input type="checkbox"/>	Participation limited to specific sports (Comment)
<input type="checkbox"/>	No Athletic Participation (Comment)

Doctor's Signature	Date:
--------------------	-------