

**SYRACUSE CITY SCHOOL DISTRICT**

Rev. 5/2013

**Pre-participation Physical Evaluation**

**MUST BE COMPLETED WITHIN 30 DAYS FROM BEGINNING OF SPORT**

**SPORT**

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Football | <input type="checkbox"/> Volleyball     |
| <input type="checkbox"/> Basketball        | <input type="checkbox"/> Golf     | <input type="checkbox"/> Wrestling      |
| <input type="checkbox"/> Bowling           | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> XCountry/Track |
| <input type="checkbox"/> Cheerleading      | <input type="checkbox"/> Soccer   | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Crew              | <input type="checkbox"/> Swimming |   |

**LEVEL**

- Modified (7<sup>th</sup>/8<sup>th</sup> Gr.)  Freshman  Junior Varsity  Varsity

- MALE  FEMALE

SCHOOL: \_\_\_\_\_

STUDENT ID# \_\_\_\_\_

**OFFICE USE ONLY**

Physical Date \_\_\_\_\_

- Approved for Sports  
 Not Approved for Sports (see notes)

Notes:

- Vision Screen:  Failed  Referral  
 Needs Physical Exam:

\_\_\_\_\_  
 (Nurse's Signature) / (Date)  
**Do not sign if student is not approved.**

Last Name	First	Age	Birthdate	Grade
Street Address _____				
City		Zip	Home Phone	
Parent's Cell Phone _____		Emergency Contact/Phone _____		

**HEALTH HISTORY FOR SPORTS PARTICIPATION**

**(To be completed by parent or guardian)**

Before the start of the tryout sessions or practice for each season, a health history must be done for each athlete.

**History since last physical examination: (include date and EXPLAIN "YES" ANSWERS BELOW)**

1.	Has student been hospitalized or had treatment in an emergency room?	Yes	No	Date:
2.	Any surgical operations, dislocations, or fractures?	Yes	No	Date:
3.	Is student presently taking any medications or pills or under a doctors care?	Yes	No	Date:
4.	Has student passed out, gotten dizzy, or had chest pain during or after exercise?	Yes	No	Date:
5.	Anyone in your family died of heart problems or sudden death before age 50?	Yes	No	Date:
6.	Ever had any vision or eye problems, wear glasses or contacts?	Yes	No	Date:
7.	Has student ever had a head injury, been knocked out, became unconscious or had a seizure?	Yes	No	Date:
8.	Has student developed any allergies since his/her last physical?	Yes	No	Date:
9.	Developed any medical problems or injuries since his/her last physical?	Yes	No	Date:
10.	Does student have any chronic illnesses?	Yes	No	Date:
11.	Does student have irregular menstrual periods?	Yes	No	Date:
12.	Last Tetanus Shot			Date:

**EXPLAIN "YES" ANSWERS:**

\_\_\_\_\_

\_\_\_\_\_

I, the undersigned, clearly understand that the health questions are asked in order to determine if my child can safely participate in the athletic activity named above. I am aware that participation in this athletic activity is voluntary and that the Syracuse City School District does not carry student/athletic insurance. In addition, I authorize release of medical information to the faculty/staff that may/will need this information for the health and safety of my child. The answers are correct as of this date and he/she, has my permission to participate.

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date