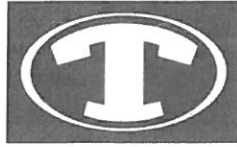


TICONDEROGA CENTRAL SCHOOL

Sports Update



Prior to the start of tryout sessions or practice at the beginning of *each season*, a Sports Update form for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT: _____ AGE: _____

GRADE: _____ BIRTHDATE: _____

SPORT: _____

If the answer to any of the following questions is "YES", please describe on the reverse side of this form the condition or situation that prompted your answer.

NOTE: "YES" to any of the questions below does not mean automatic disqualification from the athletic activity. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

The answers to the questions on this form will be held in the school health office and will be kept confidential.

Since his/her **LAST** sports physical, has your child had:

- | | | |
|--|---------|--------|
| 1. Any injuries requiring medical attention? | ___ Yes | ___ No |
| 2. Any illness lasting more than (5) days? | ___ Yes | ___ No |
| 3. Taking medicine or under physician's care at this time? | ___ Yes | ___ No |
| 4. Any feeling of faintness, dizziness, or fatigue after exercise or Exertion? | ___ Yes | ___ No |
| 5. Change in wearing glasses or contact lenses? | ___ Yes | ___ No |
| 6. Any surgical operations or fractures? | ___ Yes | ___ No |
| 7. Any treatment in a hospital or emergency room? | ___ Yes | ___ No |
| 8. Developed any allergies? | ___ Yes | ___ No |
| 9. Any chronic disease? | ___ Yes | ___ No |

Describe the condition or situation that caused any questions to be answered "YES" on the front:

PARENTAL PERMISSION:

I, the undersigned, clearly understand these questions are asked in order to decide if your child can safely participate on the athletic team. The answers are correct as of this date and he/she has my permission to participate.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Date of Last Appraisal: _____ Limitations? ___ Yes ___ No

Sports Participation: _____ Approved _____ Referred to School Physician

Signature: _____ Date: _____
(School Health Office)

If referred to the School Physician:

Re-Qualified: _____ Disqualified: _____

Physician Comments:

Signature: _____ Date: _____
(School Physician)