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:

_____

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_____

Signature: _____ Date: _____
(School Physician)