Abby Kelley Foster Charter School

REQUIRED MEDICAL and PERMISSION FORM
INTERSCHOLASTIC ATHLETICS

PARENT/GUARDIAN – Please answer the following questions & **SIGN RELEASE FORM**

Student's Name_____Sex M ( ) F( ) YOG_____HR_____
Address_____ City_____ ZIP_____
Birthdate_____Grade_____
HomePhone_____ Emergency Phone _____
Parent(s) Names_____(Work) _____ (Cell)_____
Parent(s) E-mail _____
Family Physician's Name_____Tel. # _____ School attended last year_____

STUDENT HEALTH INFORMATION

1. Food/Insect/Medication/Allergies_____
2. Current medications_____
3. Eyeglasses/contacts/hearing aids other: _____
4. Other Concerns_____

If the Nurse/Trainer/Athletic Director determines that an injury or condition has occurred that requires a medical clearance a **RETURN TO PARTICIPATION** form must be completed by the physician.

I hereby give my permission for my son/daughter to participate in the **Abby Kelley Foster High School Athletic Program** for the school year of 2015-2016.

_____ _____
SIGNATURE OF PARENT **DATE**

*All students must pass a physical examination within thirteen months before participating in any Sport. Any student who does not fulfill this requirement is considered ineligible. Contests in which the student participates in violation of this rule including **FORGED PHYSICAL EXAMINATION** must be forfeited.*

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Providers Examination

Name _____ ☐Male ☐Female Date of Birth:_____

Medical History

Pertinent Family History and Current Health Issues

Y **N**

☐ ☐ Allergies: Please list: Medications _____ Food _____
Other _____

☐ ☐ History of Anaphylaxis to _____ Epi-Pen☒ ☐Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan Yes No (*Please attach*)

☐ ☐ Diabetes: Type I Type II

☐ ☐ Seizure disorder:

_____

☐ ☐ Other (*Please specify)*

_____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

_____

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ Genitalia _____

Screening:

	(Pass)	(Fail)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead _____ Date _____ Other_____

The entire examination was normal: ☐

_____

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.

Referred for evaluation to: _____ ☐ Low risk (no PPD done)

_____

This student has the following problems that may impact his/her educational experience:

☐Vision ☐Hearing ☐Speech/Language ☐Fine/Gross Motor Deficit
☐Emotional/Social ☐Behavior ☐Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports.**
If no, please list restrictions:_____

☐Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student.