STUDENT ATHLETE HEALTH INFORMATION FORM
2020-21 SCHOOL YEAR

Student Name
(Last Name) (First Name) (Middle Initial)

____

Birth Date ____

Address_____________________________ **City** ________________________________

State _________________ **Zip Code**____

Grade Level: _______ **Gender**: M ____ F ____

In case of illness or accident to the student named above; the school is authorized to proceed as indicated below. Number each item 1,2,3,4 in order of desired action.

___ Contact Mother______________________________Phone__________________________

___ Contact Father ______________________________Phone__________________________

___ Contact Doctor______________________________Phone__________________________

___ Contact Relative/Neighbor______________________Phone__________________________

In case of injury/emergency (when parent/guardian is not available) notify:

Name: ____

Phone:____

I request that my child receive first aid services whenever such services are deemed necessary. I authorize that my child be attended by a licensed physician and/or taken to the nearest hospital in the event that his/her condition deems it necessary. I will accept the judgment of the person in charge. This permit is effective until a written notice of cancellation is given to me.

Parent / Guardian Signature: ____
Date: ____________________________________

Insurance Certification:

This certifies the above named student is covered by personal accident insurance in case of injury while participating in interscholastic athletics during the coming school year. The Diocese of Santa Rosa has an additional policy that may be purchased if the parent or guardian wishes to do so. An optional football policy will be available during football season.

Insurance Carrier: ____

Policy# ____

STUDENT HEALTH INVENTORY

Dear Parent(s):
In order to provide the best educational program for your child, the school would appreciate you providing the following health information. Please check which of the following conditions your child has/had, and give his/her age at the time of illness and whether he/she is still under care of a physician for this condition.

Condition	Approx. Age	Under Care of Physician
-Allergies (Bee Sting, Hay fever, Food, Other)		
-Asthma		
-Heart Condition		
-Diabetes		
-Kidney Disease		
-Epilepsy: Petit Mal Grand Mal		
-Frequent/Severe Headache Fainting		
-Any Speech Hearing Vision		

STUDENT HEALTH INVENTORY CONT…

Is there any other physical condition about which the school should be aware?

Is the student's physical activity limited? ____No ____Yes

If yes, is there a Physician's Statement on file with the school?

Does your child have any condition which could be a school emergency? ___No ___Yes

If yes, please provide explanation:

Is your child presently taking any medicine prescribed by the physician? (Explain)

Name of Medicine:

Time of day medicine is taken:

Please list below or on the back of this page any significant health problems that might be significant to a physician evaluating your child in case of an emergency:

DOCTOR'S CERTIFICATION

Athlete's First/Last Name: ____
Doctor's Certification: Must be dated after July 1. (Chiropractic physicals are not accepted)
This certifies that the above named student is physically able to participate in all interscholastic athletics during the coming school year, except for those listed below:

Exceptions:

Dr. Office Stamp for verification:

Physician's Name (please print): ____

Phone : ____

Physician's Signature: ____

Date:_____________________________

VOLUNTARY ACTIVITIES ACKNOWLEDGEMENT AND ASSUMPTION OF POTENTIAL RISK

(Print Student Name) ____
wishes to participate in the St. Vincent High School athletic program. I understand and acknowledge that these activities by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

- I understand and acknowledge that some of the injuries/illness which may result from participating in these activities include but are not limited to the following: Sprains/Strains, Fractured bones, Unconsciousness, Head and/or back injury, Paralysis, Loss of eyesight, Communicable diseases, and Death.
- I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the School
- I understand and acknowledge that in order to participate in these activities; I agree to assume liability and responsibility for any and all potential risks that may be associated with participation in such activities.
- I understand, acknowledge, and agree that the School, its employees, officers, agents, or volunteers shall not be liable for any injury/illness suffered by me which is incident to and/or in association with preparing for and/or participating in this activity.
- I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES ACKNOWLEDGEMENT AND ASSUMPTION OF POTENTIAL RISK INFORMATION and that I understand and agree to its terms.

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Parent/Guardian Signature　　Print Parent Name　　Date

____

Student Signature　　Print Student Name　　Date