GOSHEN CENTRAL SCHOOL DISTRICT
INTERSCHOLASTIC SPORTS PARENT PERMISSION FORM

Student's Name:_____ M/F ____ Grade ____ DOB _____

Sport _____ Level: Varsity JV Freshman Modified
(Circle one)

I grant permission for my son/daughter to participate in the above sport during the current school year.

1. We have read the Goshen Central School District Interscholastic rules and regulations and understand the purpose and direction of this athletic code.
2. Any student medically excused from physical education cannot participate in the interscholastic athletic program during the "excused time".
3. We understand physical hazards may be encountered as a result of participation in the sport. Please be aware that the Goshen Central School District carries Secondary Insurance. Any claims due to a sport injury MUST be processed through your insurance FIRST. For any questions, please call the school nurse.
4. We understand a physical is required to participate in sports.

WE HAVE READ AND ACKNOWLEDGE THE ABOVE STATEMENTS

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

PAGE 2 MUST BE COMPLETED BEFORE A STUDENT WILL BE ALLOWED TO PARTICIPATE IN AN INTERSCHOLASTIC SPORT.

MEDICAL CERTIFICATION
(To be completed by the school nurse only)

I certify that the student listed above has had a physical exam and is approved to compete in sports during the FALL/WINTER/SPRING sport season.

Date of Physical _____

Restrictions (if any):

_____
_____
_____

Nurse's Signature _____ Date _____

SPORTS CANDIDATE QUESTIONAIRE
HEALTH HISTORY <u>SINCE LAST MEDICAL</u>

NAME: _____ M/F_____ GRADE_____ SPORT_____

We understand clearly that the questions listed below are asked to decide if this student is in a proper condition to participate in the athletic activity named at the top of the form. Then answers are correct as of the date this form is signed. All answers will be kept confidentially in the student's health record in the school Health Office.

_____ _____
Signature of Student Home Phone No.

_____ _____ _____
Date Parent/Guardian Signature Business Phone No.

In the event of a **MEDICAL EMERGENCY** and a parent cannot be reached, the school is requested to contact the person I have designated to take responsibility for my child. This person is _____, and can be reached at _____.

		YES	**NO**
1.	Any injuries requiring medical attention?	____	____
2.	Any illness lasting more than 5 days?	____	____
3.	Presently taking any medication or under physician's care?	____	____
4.	Are glasses or contact lenses necessary for participation in sports?	____	____
5.	Any feeling of dizziness, chest pain or fatigue?	____	____
6.	A surgical operation of fracture?	____	____
7.	Treated in a hospital emergency room?	____	____
8.	Is there any sport the student cannot participate in due to a health problem?	____	____
9.	Any chronic disease? (asthma, arthritis, diabetes, etc.)	____	____
10.	Any known allergies?	____	____

If yes to any of the above, please describe:

_____
_____
_____
_____

_____ _____
Review checked by Nurse Date of Physical