

**St. Mary's-St. Alphonsus Regional Catholic School
Glens Falls, New York
SPORTS CANDIDATES QUESTIONNAIRE**

Name: _____ Date of Birth: _____
Athletic Activity: _____ Grade: _____

History Since Last Medical Exam

Item	Yes	No	Item	Yes	No
1. Any injuries requiring medical attention?			6. A surgical operation or fracture?		
2. Any illness lasting more than five (5) days?			7. Treated in a hospital or emergency room?		
3. Taking any medicine or under physician's care at this time?			8. Any reason why this person cannot participate in any sport?		
4. Any feeling of faintness, dizziness, or fatigue after heavy exertion?			9. Any known allergies?		
5. Wears glasses or contact lenses?			10. Any chronic disease?		

If yes to any of the above, describe: _____

PERMISSION

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

Signature of Parent/Guardian Date _____
Signature of Student Date

Note: "Yes" answers to any of the question do not mean automatic disqualification from The athletic activity indicated. They will require review and evaluation by the school physician.

FOR OFFICE USE ONLY

(Please do not write below this line)

Date of last tetanus booster (within 10 years): _____

Date of last medical exam: _____ Physician: _____

Were any defects noted in last exam or past school health record? Yes No

If yes, describe: _____

Were any chronic diseases noted in the last exam or past school health record? Yes No

If yes, describe: _____

DISPOSITION

Approved Referred Date RN

Approved Not Approved Date MD

Remarks: _____
