

MELROSE HIGH SCHOOL
360 LYNNFELLS PARKWAY
MELROSE, MA 02176
781-462-3223
FAX: 781-979-2131

DEPARTMENT OF PHYSICAL EDUCATION
HEALTH & ATHLETICS
PATRICIA RUGGIERO, DIRECTOR
LINDA CHAMBERS, SECRETARY

**WINTER SPORT
PERMISSION FORM**

SCHOOL YEAR _____

To participate in the interscholastic athletic program, students must pass a sports physical examination, have the permission of their parents or guardian, and maintain satisfactory scholarship and citizenship standings, according to the Interscholastic Athletic Association.

The school department is not liable for expense, medical or otherwise, incurred during participation in interscholastic sports.

**TO BE COMPLETED BY PARENT OR GUARDIAN
PLEASE COMPLETE BOTH SIDES**

DATE OF BIRTH _____

CIRCLE CHOICE

**BOYS BASKETBALL
BOYS SWIMMING**

**HOCKEY
INDOOR TRACK**

**WRESTLING
GYMNASTICS**

**GIRLS BASKETBALL
GIRLS HOCKEY**

Student Name _____ Grade _____ Home Room _____

Address _____ City/Town/Zip _____

Parent or Guardian _____

Address _____ City _____

Tel: () _____ - _____ Work () _____ - _____ Emergency () _____ - _____

I have read and understand the statements on this form and all attached forms-Hazing, Eligibility, Participation Guidelines and Parent Information sheet. I give permission for my son/daughter to participate in the interscholastic sport indicated above. I understand that Melrose is responsible only for first aid treatment in the event of illness or injury.

Parent or Guardian Signature _____ Date ____/____/____

I have received a copy of Chapter 536 of the acts of 1985-an act of prohibiting the practice of hazing.

Signature of Student

Parent's Insurance Company _____ Policy # _____

SCHOOL OFFICE USE ONLY

Physical by Dr. _____ Date ____/____/____ Nurse Initials _____

Restraints or Comments:

HEALTH SERVICES DEPARTMENT SPORTS CANDIDATE MEDICAL QUESTIONNAIRE

Diane Ely, R.N. Melrose High School Nurse - Nurse's Office Ext. 781-979-2236

State law requires that students must have an annual physical before they can participate in Interscholastic Sports. Results of a physical and completion and return of this form are required prior to practicing or competing.

TO BE COMPLETED BY PARENT/GUARDIAN

DATE: ____/____/____

Name of Student _____ Grade _____ Home Room _____

Date of Birth ____/____/____

Address _____ City or Town _____

Physician's Name _____

Address _____ Tel () _____ - _____

Does your child have, or has your child had, a disease or condition that affects the function of eyes, ear, testicles, kidneys or lungs? _____ If so, explain: _____

Has your child seen a doctor in the past two years? _____ If so, explain: _____

Any illness, surgery, fractures, sprains, strains, joint or back injuries, bone dislocation, serious or otherwise? _____ Give dates _____

Under care for any medical condition? _____ If so, what? _____

Take any medications? _____ For what? _____
Name of Medication, dose, when taken

Wear a brace or support? _____ For what? _____ Glasses/Contacts _____
Type

Has your child ever had any of the following? If so, please give dates:

Asthma and or Allergies _____	Blood Disorders _____
Fainting or loss consciousness _____	Mononucleosis _____
Heart Murmur/Heart Condition _____	Diabetes _____
Rheumatic Fever _____	Pneumonia _____
Kidney Disease or Injury _____	Hepatitis _____
Heat Stroke/Heat Exhaustion _____	Bronchitis _____
Mental Emotional Problems _____	Tumors _____
Serious Dental Problems _____	Hernia _____
Seizure/Convulsions _____	Chest Pains _____
Menstrual Problems _____	Paralysis _____
Head Injury/Concussion _____	Other _____

Further comments? Attach extra comments to this form

I have read and understand the statements on this form and will allow my son/daughter to participate in interscholastic sports.
Signature of Parent/Guardian _____

MELROSE PUBLIC SCHOOLS

360 Lynn Fells Parkway
Melrose, MA 02176

Away Sports Competition/Field Trip
Parental Consent, Release from Liability, and Indemnity Agreement
School Year _____

We the undersigned father and mother or guardian(s) of _____, a minor, do hereby consent to his/her participation in field trip to _____ on _____ and do forever RELEASE, acquit, discharge, and covenant to hold harmless the City of Melrose, a municipal corporation of the Commonwealth of Massachusetts, and its successors, departments, officers, employees, servants, and agents, of and from any and all actions, causes of action, claims, demands, damages, costs, loss of services, expenses and compensation on account of, or in any way growing out of, directly or indirectly, all known and unknown personal injuries or property damage which we/I many now or hereafter have as the parent(s) or guardian(s) of said minor, and also all claims or right of action for damages which said minor has or hereafter may acquire, either before or after he/she has reached his/her majority resulting or to result from his/her participation in this field trip of the Melrose Public Schools; FURTHERMORE, we/I hereby agree to protect the City of Melrose and its successors, departments, officers, employees, servants and agents against any claim for damages, compensation or otherwise on the part of said minor growing out of or resulting from injury to said minor in connection with his/her participation in the Melrose Public Schools' field trip, and to INDEMNIFY, reimburse or make good to the City of Melrose or its successors, departments, officers, employees, servants and agents any loss or damage or costs, including attorney's fees, the city or its representatives may have to pay if any litigation arises from said minor's intentional, grossly negligent, or recklessness acts or omissions while participating in said field trip.

Signature(s) of Parent(s) or Guardian(s)

Date

Relationship

Signature of Student

This form may not be altered

Complete Reverse side

Student's Last Name	First Name	Middle Initial
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Home Address	Town	Zip Code
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Telephone Number	Date of Birth (A copy of birth certificate may be required)	Grade
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IN CASE OF EMERGENCY CALL:

NAME	TEL. NO.	RELATIONSHIP
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NAME	TEL. NO.	RELATIONSHIP
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NAME	TEL. NO.	RELATIONSHIP
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Family Health Insurance Plan	Policy Number
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PLEASE USE ADDRESS STAMP IF POSSIBLE.

DATE OF EXAM. ____/____/____

PRIVATE PHYSICIAN'S EXAMINATION

In order to ensure a quality standard of complete examination for each school child, please record your findings after each item.

(O) normal (X) abnormal

Date ____/____/____ Name of Student _____

Comment _____ Treatment _____

Age _____ BP ____/____ Pulse _____ Height _____ Weight _____

Physical Development _____

Nutritional Status _____ Skin _____

Eyes _____ sclera _____ pupils _____ V OD _____

OS _____ Color Blindness _____
Light & distance R _____ L _____

Glasses _____

Ears _____ canals R _____ L _____ drums R _____ L _____

Nose _____ septum _____ turberates _____

Mouth _____ lips _____ tongue _____ pharynx _____

Teeth _____ gingiva _____ Last Visit ____/____/____

Neck _____ mobility _____ lymph nodes _____ thyroid _____

Throat _____ shape _____ symmetry _____

Lungs _____

**In order for this student to be cleared
to participate in sports for the year,
Please circle one:**

Heart _____ rate _____ rhythm _____ murmur _____

Abdomen _____ liver _____ spleen _____ **May** **May Not**

hernia _____ **PARTICIPATE IN INTERSCHOLASTIC**
Ano-Genital _____ anus _____ penis _____ labia _____ **SPORTS.**

Testicles R _____ L _____
Tannerstage _____

Spine _____

**PLEASE RECORD IMMUNIZATION
DATA ON THE OPPOSITE SIDE OF
THIS FORM.**

Lower Extremities _____ range of motion _____

Development _____ strength _____

Upper extremities _____ range of motion _____

Development _____ strength _____

Cranial Nerve _____ IXII _____

Gait _____

Speech _____

Identifying Marks _____

Coordination _____

LAB TESTS

HGB/HCT

URINALYSIS

Specific Gravity _____ PROTEIN _____ SUGAR _____ CELLS _____ BACTERIA _____ URICULT _____

