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

FALL 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

CROSS COUNTRY	**FOOTBALL**	**SOCCER**	**VOLLEY BALL**
GOLF	**GIRLS SWIMMING**	**GIRLS SOCCER**	**FIELD 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 QUESTIONAIRE

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________________________________

Fainting or loss consciousness___________________________

Heart Murmur/Heart Condition ___________________________

Rheumatic Fever ______________________________________

Kidney Disease or Injury ________________________________

Heat Stroke/Heat Exhaustion _____________________________

Mental Emotional Problems ______________________________

Serious Dental Problems _________________________________

Seizure/Convulsions ____________________________________

Menstrual Problems_____________________________________

Head Injury/Concussion _________________________________

Blood Disorders________________________________

Mononucleosis_________________________________

Diabetes ______________________________________

Pneumonia ____________________________________

Hepatitis_______________________________________

Bronchitis ______________________________________

Tumors ____

Hernia ____

Chest Pains_____________________________________

Paralysis _______________________________________

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

Home Address	Town	Zip Code

Telephone Number	Date of Birth (A copy of birth certificate may be required)	Grade

IN CASE OF EMERGENCY CALL:

NAME	TEL. NO.	RELATIONSHIP

NAME	TEL. NO.	RELATIONSHIP

NAME	TEL. NO.	RELATIONSHIP

Family Health Insurance Plan	Policy Number

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 __________

Heart ______ rate _____ rhythm_______ murmur _________

Abdomen ________ liver ________ spleen ____________

hernia _____________

Ano-Genital_______ anus _______ penis _____ labia ______

Testicles R _______ L _________

Tannerstage _______________________

Spine _________

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 _________

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

May **May Not**

PARTICIPATE IN INTERSCHOLASTIC SPORTS.

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

Physician's Signature____Date__________________________

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF IMMUNIZATION

NAME ____ **DATE OF BIRTH** _____/______/_____

SEX FEMALE ☐ MALE ☐

Vaccine **Date**

Hepatitis B 1 ________________
2 ________________
3 ________________

Vaccine **Date**

HIB 1__________
2 __________
3 __________
4 __________

PLEASE CHECK APPROPRIATE BOX

DTB	DTB	DT	TD	Date
☐	☐	☐	☐	1 ____________
☐	☐	☐	☐	2 ____________
☐	☐	☐	☐	3 ____________
☐	☐	☐	☐	4 ____________
☐	☐	☐	☐	5____________

IPV	OPV	Date
☐	☐	1 ____________
☐	☐	2 ____________
☐	☐	3____________
☐	☐	4____________

Rotavirus 1 ____________
2 ____________
3 ____________

MMR 1 __________
2 __________

Varicella 1 __________
2 __________

Hepatitis A 1 __________
2 __________

Pneumococcal 1 __________
2 __________

Influenza 1 ___________
2 ___________
3 ___________

Other:
____
____

Chickenpox History

☐ **Check the box if this person has a Physician-certified reliable history of chickenpox.**
Reliable history may be based on:

- **physician interpretation of parent/guardian description of chickenpox**
- **physical diagnosis of chickenpox, or**
- **seriologic proof of immunity**

PERTINENT FAMILY MEDICAL HISTORY

SUMMARY OF SIGNIFICANT TREATMENT PROGRAMS INCLUDING CURRENT MEDICATIONS AND SUGGESTIONS FOR PROGRAM ADJUSTMENT IF INDICATED.
I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse' name: ____ **Date** ______/______/_____

PLEASE PRINT