

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  
DENISE DAGLIO, SECRETARY

**SPRING 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.

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TO BE COMPLETED BY PARENT OR GUARDIAN  
PLEASE COMPLETE BOTH SIDES

DATE OF BIRTH \_\_\_\_\_

**CIRCLE CHOICE**

**BASEBALL  
SOFTBALL**

**BOYS LACROSSE  
GIRLS LACROSSE**

**BOYS TRACK  
GIRLS TRACK**

**BOYS TENNIS  
GIRLS TENNIS**

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 # \_\_\_\_\_

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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.

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

Date

Relationship

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Signature of Student

**This form may not be altered**

**Complete Reverse side**

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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:**

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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 \_\_\_\_\_



