Rochester City School District
Department of Health, Physical Education, & Athletics
Department of Student Health Services
Medical Requalification & Parent/Guardian Consent Form

School Attending: _____
Desired Sport: _____
Desired Level: Modified Freshman JV Varsity

Student Name: _____ Gender: M F Birthdate: _____ Age: _____
Name of Parent/Guardian: _____ Parent/Guardian Phone Number: _____
Name of Emergency Contact: _____ Emergency Contact Phone Number: _____
Address & Zip: _____ Grade: _____ Date Entered Grade 9: _____
Name of Physician & Health Center: _____ Date of Last Physical: _____

Student Athlete: You must requalify with the school nurse no earlier than 30 prior or 14 days after the first day or practice. Please bring this completed and signed form, documentation of a current physical examination, if not already provided, and your glasses or contacts, inhaler, epinephrine injector, MD orders, or any other medical requirements indicated on your current physical examination.

	Yes	No
1. Have you had a medical illness, injury, or new diagnosis since your last physical?	☐	☐
2. Has a physician ever restricted or denied your participation in sports for any reason?	☐	☐
3. Have you ever been hospitalized overnight or had a surgery?	☐	☐
4. Do you have any life-threatening allergies or medical conditions?	☐	☐
5. Are you currently taking or using any prescription or over-the-counter medications, including an inhaler?	☐	☐
6. Do you have chest pain, dizziness, fainting, or irregular heartbeats during or after exercise?	☐	☐
7. Has a family member or relative died of heart problems or of sudden death before age 50?	☐	☐
8. Have you had mononucleosis, myocarditis, or other severe viral infections in the last six months?	☐	☐
9. Are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
10. Do you have anemia, bleeding problems, or any other blood-related problems?	☐	☐
11. Do you have or have you ever had seizures, a head injury or concussion, or any other neurological problems?	☐	☐
12. Have you ever had heat cramps, heat exhaustion, heat stroke, or other temperature regulation problems?	☐	☐
13. Do you have asthma or cough, wheeze, or have trouble breathing during or after exercise?	☐	☐
14. Do you have any rashes, sores, or other skin problems?	☐	☐
15. Do you have any hearing problems or use hearing aids?	☐	☐
Females:		
30. Have you had your first period? If so, at what age? _____	☐	☐
31. When was your most recent menstrual period? _____		
32. Has there been a recent change in your menstrual patterns?	☐	☐
33. Is your period less than 21 days or more than 35 days apart?	☐	☐

	Yes	No
16. Do you have any vision problems or wear glasses, contacts, or protective eyewear?	☐	☐
17. Have you ever had a hernia or other serious abdominal problems?	☐	☐
18. Do you have diabetes or other metabolic problems?	☐	☐
19. Have you ever had a broken or fractured bone, dislocated joint, or stress fracture?	☐	☐
20. Have you ever had any injuries to a bone, muscle, ligament, or tendon, or joint or other orthopedic problems?	☐	☐
21. Do you regularly use a brace, orthotics, or other protective or assistive equipment?	☐	☐
22. Do you regularly lose weight to control or meet weight for your sport?	☐	☐
23. Have you had an unexpected weight loss or gain in the last six months?	☐	☐
24. Are you currently following any particular diet to control or reduce weight?	☐	☐
25. Are you currently using vomiting, laxatives, diet supplements, or excessive exercise to control or reduce weight?	☐	☐
26. Do you have a history of eating disorders?	☐	☐
27. Do you take or use any supplements or drugs to improve your performance?	☐	☐
28. Do you currently have any medical concerns that you would like to discuss with your doctor?	☐	☐
29. Date of last tetanus vaccination: _____		

Explain "Yes" answers below:

_____
_____
_____

Parent or Guardian: My signature below indicates the following: 1) I have correctly completed the questions above with my student, and to the best of my knowledge, there is no medical reason that should exclude him/her from athletic participation. 2) I give permission for my student to participate in athletics, and if necessary, for my student to receive medical evaluation and treatment to ensure his/her health, safety, and well-being. 3) I understand that if my student requires medical attention from his/her physician or another medical professional, he/she must provide documentation of a clearance given from the physician or medical professional prior to returning to physical education and athletics. 4) In the event that I cannot be reached, I authorize the RCSD staff to act on my behalf and at my expense according to his/her best judgment in any emergency requiring medical or surgical care for my child. I authorize the selected physician to use his/her medical judgment to order/secure necessary treatment for my child, including, but not limited to surgery or hospitalization. I understand that every reasonable effort will be made to reach me should an emergency arise.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse:

☐ *The above student is qualified to participate in athletics.*
☐ *With requirements:* _____
_____

School Nurse Signature: _____
Date: _____
Date of Last Physical: _____