The WALDORF SCHOOL of GARDEN CITY

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# ATHLETIC HEALTH HISTORY / PERMISSION SLIP

**MUST BE COMPLETED BY PARENT OR GUARDIAN WITHIN 10 DAYS PRIOR TO THE START OF EACH SPORT SEASON.**

Student's Name _____ Date _____

Date of Birth _____ Home Telephone (____) _____

SPORT _____ Current Grade _____

Emergency Contact _____ Telephone (____)_____

Emergency Contact _____ Telephone (____)_____

Please note that we also require a current physical examination on record for all students participating in an extracurricular sport. (Contact medical office for specific information.) Additionally, the following information is required. Incomplete forms will be returned and students will not be permitted to participate until the form is completed and approved by the medical and athletic offices.

## HEALTH HISTORY

*(to be completed by parent/guardian)*

Does your child have (please check):

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Allergies/HayFever | ☐ | ☐ | Hearing Loss | ☐ | ☐ | Back Pain/Injury | ☐ | ☐ |
| Bee Sting Allergy | ☐ | ☐ | Musculoskeletal | | | Rheumatic Fever | ☐ | ☐ |
| Asthma | ☐ | ☐ | Disorder/Injuries | ☐ | ☐ | Stomach Ulcer | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Elevated Blood Pressure | ☐ | ☐ | Injury to the Spleen | ☐ | ☐ |
| Bladder/Kidney | ☐ | ☐ | Head Injury/Concussion | ☐ | ☐ | Only One Testicle | ☐ | ☐ |
| Liver Injury | ☐ | ☐ | Heart Problem | ☐ | ☐ | Only One Kidney | ☐ | ☐ |
| Convulsions/Seizures | ☐ | ☐ | Nose Bleeds | | | Only One Eye | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Frequent or Severe | ☐ | ☐ | Eyeglasses/Contact Lenses | ☐ | ☐ |

EXPLAIN ALL "YES" ANSWERS _____

Is your child taking any medication at this time? Yes ____ No ____ If Yes, please specify _____

Are there any changes or new medical conditions concerning your child? Yes ____ No ____

If Yes, please specify _____

I, _____, AM THE PARENT/LEGAL GUARDIAN OF _____

WHO WAS BORN ON _____ AND WHO RESIDES AT _____

I AUTHORIZE A FACULTY MEMBER OF THE WALDORF SCHOOL OF GARDEN CITY TO CONSENT TO ANY EMERGENCY TREATMENT WHICH MAY BE NECESSARY FOR MY CHILD NAMED ABOVE IN CASE OF ILLNESS OR INJURY AFTER EFFORTS TO CONTACT ME ARE UNSUCCESSFUL. SUCH TREATMENT MAY INCLUDE, BUT IS NOT LIMITED TO, EXAMINATION, X-RAYS, LABORATORY TEST, MEDICAL AND SURGICAL TREATMENT, USE OF MEDICATION, ANESTHESIA AND/OR SUTURES AS WELL AS ADMISSION FOR HOSPITAL CARE AS MAY BE REQUIRED. I UNDERSTAND THAT SUCH CARE WILL BE BASED UPON MEDICAL ADVICE.

_____day of _____, 20 _____ _____

*SIGNATURE*

I hereby give permission for my child to participate in _____ for the Fall / Winter / Spring year _____

IT IS UNDERSTOOD THAT IN THE EVENT OF AN INJURY TO THE STUDENT, THE SCHOOL IS DELEGATED ONLY TO RENDER FIRST AID AND IS NOT OBLIGATED TO COMPENSATE FOR OR INSURE AGAINST RELATED MEDICAL EXPENSES. MEDICAL EXPENSES RESULTING FROM AN INJURY INCURRED WHILE PARTICIPATING IN A SCHOOL ACTIVITY MUST BE SUBMITTED FIRST TO THE FAMILY'S OWN INSURANCE CARRIER. I ALSO UNDERSTAND THAT IT IS THE ATHLETE'S (STUDENT'S) RESPONSIBLILITY TO REPORT ALL INJURIES WITHIN 10 DAYS OF OCCURRENCE IN ORDER FOR ANY INSURANCE CONSIDERATION AFTER PARENTS' INSURANCE SETTLEMENT.

_____ _____

PARENT/GUARDIAN Signature Date HEALTH OFFICE Approval Date

PLEASE RETURN THE COMPLETED FORM TO THE HEALTH OFFICE FOR DISTRIBUTION