SPANISH RIVER CHRISTIAN SCHOOL
STUDENT ACKNOWLEDGMENT
PARENTS PERMISSION TO ADMINISTER EMERGENCY MEDICAL CARE

Student's Name: ___________________________________

This application to compete in interscholastic athletics for Spanish River Christian School is entirely voluntary on my part and is made with the understanding that I have not violated any eligibility rules and regulations set forth by Spanish River Christian School.

Date ________________ Signature of Student: ____

PARENTS' OR GUARDIANS' PERMISSION
(Parent or Guardian to Read and Sign)

I certify the above information is true, and I consider him/her physically capable of participating in athletics. I hereby give my consent for the above-named student to represent Spanish River Christian School in athletic activities, except those cited by the examining physician, and to accompany the school team of which he/she is a member on any of its local or out of town trips.

I (We) do hereby release, forever discharge and agree to hold harmless Spanish River Church and Christian School and the directors, agents, servants, volunteers, and employees thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the participant that occur while said person is participating in the above-described trip or activity including recreation and work activities. The undersigned further hereby agrees to hold harmless and indemnify said church, its directors, agents, servants, volunteers, and employees for any liability sustained by said acts of said participant, including expenses incurred attendant thereto.

The undersigned further consents to the administration of first-aid and/or doctor's care, for the above-named student, or any other form of medical treatment necessitated by illness or injury that may require the same, including surgery, in the event that the parents/legal guardians cannot be contacted. In the event of the necessity of such care or treatment as heretofore described, the undersigned agrees to hold harmless and indemnify said church, its directors, employees and agents from any acts of malfeasance, and/or failure to act on the part of those chosen to administer medical care on behalf of the participant.

It is also understood that financial responsibility for medical treatment or services is that of the parents/legal guardians individually or through their family medical coverage.

I also give my consent for the above named student to travel with SRCS parents or staff members to athletic events throughout the school year. I understand that it is my responsibility to pick the student up from the event or from school at the designated time.

Signed:_____________________________ Date:________ Signed:_____________________________ Date:_______

STATE OF FLORIDA, COUNTY OF PALM BEACH

On this _____day of _______________, 20____, before me personally came_________________________________, to me personally known and known to me to be the same person described in and who executed the foregoing Permission to Administer Emergency Medical Care, and he/she acknowledged to me that he/she executed same.

____
Notary Public

IN CASE OF EMERGENCY, OR TO PICK UP A SICK OR INJURED CHILD, NOTIFY (Other than Parents or Guardian): Please provide us with two names (neighbors, housekeeper or other local contacts).

Name:____ Name:____

Address:____ Address:______________________________________

____ ____

Telephone: (   )________________________________ Telephone: (   )_____________________________

Relationship:_____________________________________ Relationship:__________________________________

Physician's Name:__________________________________ Telephone: (   )_____________________________

Dentist's Name:____________________________________ Telephone: (   )_____________________________

Health Insurance Company:___________________________ Policy Number:_________________________________

Allergies:____

PLEASE RETURN COMPLETED FORM TO: Athletic Director's Office
Spanish River Christian School
2400 Yamato Rd
Boca Raton, FL 33431
(561) 994-5006 Fax 994-1160

SPANISH RIVER CHRISTIAN SCHOOL
STUDENT ATHLETIC HEALTH EXAMINATION FORM

THIS FORM MUST BE FILLED OUT COMPLETELY BEFORE STUDENT IS ALLOWED TO PRACTICE AND/OR COMPETE.

Student's Name:______________________________ Age:______ Sex:______ Date of Birth:_____________ Grade___

Address:____ PARENT'S E-MAIL____________________________

Parent's/Guardian's Name:______________________________ Home Phone:______________ Work Phone:________________ Cell Phone: ____________

I. HEALTH HISTORY (To be completed by student and parents)

Check YES or NO in appropriate box for each of the following questions.

	YES	NO	
1.			Any chronic or recurrent illness?
2.			Any illness lasting more than a week?
3.			Any hospitalization?
4.			Any surgery other than tonsillectomy?
5.			Any injuries requiring treatment by a physician?
6.			Any problem with blood pressure or heart?
7.			Any dizziness, fainting, convulsions or frequent headaches?
8.			Any knee injury?
9.			Any knee surgery?
10.			Any ankle injury?
11.			Any neck injury?
12.			Any other joint sprains or dislocations (shoulder, wrist)?
13.			Any broken bones (fractures)?
14.			Any heat exhaustion or heat stroke?

SINCE YOUR LAST ATHLETIC PRE-PARTICIPATION PHYSICAL:

	YES	NO	
15.			Have you started taking any medication?
16.			Have you been knocked out or had a concussion?
17.			Have you started wearing eyeglasses or contact lenses?
18.			Have you started wearing any dental appliances such as braces, bridge, or plate?
19.			Have you become allergic to ANY medications (aspirin, penicillin, etc.)
20.			Do you have to stop while running around 1/4-mile track twice?
21.			Have any members of your family had heart problems under the age of 50?
22.			Has anyone in your close family ever had diabetes (high sugar in blood)?
23.			Has anyone under age 50 in your family died suddenly?

Date of last known tetanus shot:__________________

If you answered YES to any of the above questions, please attach explanation or provide additional information, if necessary.

II. EXAMINATION (To be completed by a physician)

Height:_____________ Weight:_____________ BP:_______/_______

Temp.:______________ Pulse:______________ Vision: Left:_______/_______

Right:______/_______

EXAM:	Normal	Abnormal
Head and Neck	( )	( )
Chest	( )	( )
Cardiovascular	( )	( )
Abdomen	( )	( )
Hernia	( )	( )
Bones and Joints	( )	( )
Neurological	( )	( )

Other tests or examinations, if conducted:____

The above named person is fit for exercise, sports or agility testing involving substantial and continual physical effort for the 2013-14 school year.

YES ( ) NO ( )

Comments:____

M.D. stamp

Date of examination:_________________ Physician signature:_____________________________________