

# Connecticut Technical High School System Interscholastic Athletics History, Permission & Physician's Release Form

School: \_\_\_\_\_

Date Received \_\_\_\_\_

**PARENT/GUARDIAN: PLEASE COMPLETE BOTH SIDES OF THIS FORM.**

This form plus a physical exam form must be on file with the School Nurse before the student may practice or play a sport. Physical exams are valid for 13 months from the date of exam. A new permission and release form is required every 13 months.

## Section 1: To Be Completed by Student

### Student Agreement:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade \_\_\_\_\_ Shop \_\_\_\_\_ Sport(s): \_\_\_\_\_

*This application to compete in supervised interscholastic athletics for the above school is entirely voluntary on my part. I certify that I have not violated any of the eligibility rules and regulations of the Connecticut Interscholastic Athletic Conference (CIAC).*

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

## Section 2: To Be Completed by Parent/Guardian

**Parent/Guardian's Permission:** *I give my consent for the above student to participate in interscholastic athletics and to accompany the team, as a member, on trips to any interscholastic games and consent to the necessary transportation for such trips.*

*I understand that high school athletics involve the potential for injury which is inherent with any sport. I am aware that even with the best coaching, supervision, protective equipment and strict observation of the rules that there is still a potential for injury. On rare occasions, injuries could result in total disability or death.*

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
(street address, city, zip code)

**Emergency Contact #1 Info:** Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
(street address, city, zip code)

**Emergency Contact #2 Info:** Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
(street address, city, zip code)

## Section 3: To Be Completed by Physician or Other Healthcare Provider:

(Please see health history on reverse)

**Medical Release:** I certify that I examined this student on \_\_\_\_\_, and that based on this exam, the student is cleared for all sports with the following restrictions \_\_\_\_\_.

Additional recommendations: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Stamp:

**Reverse Side  
Must Be  
Completed**

**Healthcare Provider:  
Please Attach a Copy of a  
Physical Exam Completed in  
the Last 13 Months  
(Any Physical Form is Acceptable)**

**Connecticut Technical High School System**  
**Interscholastic Athletics Medical History to Be Completed by Parent/Guardian**

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does your child have allergies?  No  Yes If yes, please list allergies: \_\_\_\_\_

Has your child ever had to carry a bee sting kit, Epipen, or other allergy medication?  
 No  Yes If yes, name of medicine: \_\_\_\_\_

Does your child take medicine every day?  No  Yes  
If yes, name of medicine: \_\_\_\_\_

Does your child have?  Contacts  Glasses  Braces  Loose Teeth  False Teeth

**Has your child ever had any of the following?**

Asthma or use an inhaler or other medicine for asthma?  No  Yes  
If yes, name of medicine: \_\_\_\_\_

Kidney problems, only one kidney or kidney disease?  No  Yes  
If yes, explain \_\_\_\_\_

Problems with bruising or bleeding easily or trouble stopping bleeding?  No  Yes  
If yes, explain \_\_\_\_\_

Seizures, Epilepsy or Convulsions?  No  Yes If yes, explain \_\_\_\_\_

Diabetes, low blood sugar or high blood sugar?  No  Yes If yes, explain \_\_\_\_\_

Fainting spells?  No  Yes If yes, explain \_\_\_\_\_

Have a concussion, head injury, been knocked out or unconscious?  No  Yes  
If yes, explain \_\_\_\_\_

High blood pressure or heart problems?  No  Yes If yes, explain \_\_\_\_\_

A serious eye injury?  No  Yes If yes, explain \_\_\_\_\_

A spine, neck or back injury?  No  Yes If yes, explain \_\_\_\_\_

Bone, joint, neck or back pain?  No  Yes If yes, explain \_\_\_\_\_

A broken bone, fracture, sprain or strain?  No  Yes  
Yes If yes, explain \_\_\_\_\_

Ankle, foot or knee problems?  No  Yes If yes, explain \_\_\_\_\_

An Operation?  No  Yes If yes, explain \_\_\_\_\_

Any other health problems?  No  Yes If yes, explain \_\_\_\_\_

The medical history that I supplied above is correct to the best of my knowledge

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**(Reverse Side Must Be Completed)**