

INTERSCHOLASTIC ATHLETICS

A physical examination is required annually for participation in interscholastic sports.

PARENTS'/GUARDIANS' PERMISSION

I hereby give my consent for the student named on this form to represent his/her school in interscholastic activities as approved by the physician on the previous page. I also give my permission for him/her to accompany the team on its out-of-school trips and will not hold the school responsible in case of accident or injury. I also give consent and authorize the school to obtain, through a physician of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities.

Is the student covered by insurance? _____

Company: _____

Certificate(Group) number: _____

Signatures of parents/guardian (s) _____

**APPLICATION TO PARTICIPATE IN
INTERSCHOLASTIC ATHLETICS AT
JOHN F. KENNEDY CATHOLIC HIGH SCHOOL**

Student Name: _____

Date of Birth: _____

Place of Birth: _____

This application to represent John F. Kennedy Catholic High School in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards required to represent John F. Kennedy Catholic High School and that I have not violated any of them.

Student Signature: _____

Date: _____

This form will remain on file in the Main Office.

John F. Kennedy Catholic High School
Health Examination (entering 9th grade)/All Sports Participation
FAX 636-227-0298

MUST BE COMPLETED AFTER February 1st

Student Last Name _____ First _____ MI _____ Graduation Yr _____

Birth Date _____ Phone: _____

Parent/Legal _____

Guardian: _____

Address _____

In accordance with the St. Louis County Health Commissioner, all students must have a complete physical examination upon entrance into high school. All immunization dates must include the month-day-year. No student will be permitted to start classes unless this form is in the files. **THIS FORM MUST BE TURNED IN BY JULY 31st.**

HEALTH HISTORY:

ALLERGIES _____

ASTHMA _____

EPILEPSY _____

DIABETES _____

CHICKEN POX _____

OTHER SERIOUS ILLNESS _____

SURGERIES _____

HISTORY OF ANAPHYLAXIS (severe allergic reactions): _____

UNDER TREATMENT AT THIS TIME: _____

MEDICATIONS: _____

IMMUNIZATION RECORD

Missouri state law mandates satisfactory evidence of required immunizations when entering any school. Please fill in the **month/day/year** your child received the following immunizations. Please update information as necessary.

DPT Three doses of DPT-one dose received by age 4 or greater-if not additional dose required. A booster dose of diphtheria toxoid is required 10 years from last immunization.

POLIO Three doses of trivalent oral polio vaccine-the last dose must have been received at age 4 or greater-if not, an additional dose is required.

MEASLES One dose of live measles vaccine is required at age 12 months or greater, plus a booster shot.

RUBELLA One dose of live rubella vaccine required at age 12 months or greater

HEPATITUS B (HB) Three doses of HB – 1st injection, 1month later, 5 months later

DPT Series _____ **Boosters** _____

Most Recent Tetanus _____

POLIO Series _____ **Boosters** _____

MEASLES _____ **RUBELLA** _____

MUMPS _____

HEPATITIS B _____

TUBERCULOSIS TEST: Type _____ Date _____ Result _____

OTHER IMMUNIZATIONS:

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

FOLLOW UP NOTES:

PHYSICAL EXAMINATION (please check all items examined)

Height _____ Weight _____ Lymph Glands _____
Ears _____ Vision R _____ L _____ Both _____
Pulse _____ Abdomen _____ Hernia _____ Genitalia _____
Nose _____ Throat _____ Heart _____ Lungs _____
Teeth and Gums _____ Posture _____ Reflexes _____

Details on positive findings:

I certify that I have, on this date, examined this student and, from the limited examination above, I can detect no reason not to participate in the supervised activities listed below (*Please cross off any activity in which the student should NOT participate*)

- Basketball
- Baseball
- Cheerleading
- Cross Country
- Football
- Golf
- Poms
- Soccer
- Softball
- Swimming
- Tennis
- Track
- Volleyball
- Physical Education Class

Do immunizations comply with state law? _____

Date of examination: _____

Signature of Examining Physician: _____

Print Name of Physician: _____

Telephone number of physician: _____

Preferred hospital : _____

Additional comments:

