

**ISLIP UNION FREE SCHOOL DISTRICT  
STUDENT SPORT PARTICIPATION FORM**

Rev. 01/03

To be completed and signed by the parent and returned to the Nurse's Office. **PLEASE CHECK: MALE  FEMALE**   
(PLEASE PRINT)

STUDENT'S NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_ AGE: \_\_\_\_\_

**A. GENERAL FAMILY HISTORY**

	YES NO		YES NO		
Has anyone in your family (parents, aunts uncles), had or now has:					
Diabetes _____			Recurring severe headaches _____		
Allergies _____			Convulsions or Epilepsy _____		
Asthma _____			Fainting Spells _____		
Epilepsy _____			Reaction to insect stings _____		
Has anyone in your family died suddenly under 50 years of age? _____			Very bad vision in one eye _____		
Tendency to Bleed _____			Wear Glasses or Contact Lens _____		
Heart Disease _____			Dental Plate (dentures) _____		
High Blood Pressure _____			Orthodontia (braces/caps) _____		
Marfan's Syndrome _____			Hernia _____		
			Loss of a kidney _____		
			Bone Fracture (broken bone) _____		
			Joint Dislocation _____		
			Spine or Limb Deformity _____		
			Back Injury _____		
			Knee Injury _____		
			Asthma _____		
			Reaction to insect stings/medication _____		
			Does your child take medication regularly? Name: _____		
			Take medication for emergency use? Name: _____		
			Has your child ever had an operation? Describe: _____		
			Ever been hospitalized more than 24 hours? Describe: _____		
			Date of last tetanus shot: _____		

**B. STUDENT HISTORY**

	YES NO	
Has your child had:		
Heart Murmur _____		
High Blood Pressure _____		
Chest Pains with exercise _____		
Rapid or Irregular heart beats _____		
Shortness of Breath _____		
Rheumatic Fever _____		
Tendency to bleed or bruise easily _____		
Hepatitis _____		
Mononucleosis _____		
Yellow Jaundice _____		
Diabetes _____		
Skull Fractures _____		
Sickle Cell Anemia _____		
Brain Concussion (head injury) _____		

If there are any yes answers to the above questions, please give date and further explanation below: \_\_\_\_\_  
\_\_\_\_\_

I am aware that practicing and playing in any sport can be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of practicing and playing in a sport include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, bones, joints, ligaments, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of practicing and playing in a sport may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life. Football, wrestling, baseball, basketball, soccer, lacrosse and softball are more dangerous collision/contact sports involving greater risk of injury than other sports.

I have read the above statement and I give permission for my child to participate in the following sport: \_\_\_\_\_

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

Because of the dangers of participating in the above sports, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc. and agree to obey such instructions. I have read the above warning,

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_ Telephone \_\_\_\_\_

**ISLIP PUBLIC SCHOOLS  
ATHLETE'S EMERGENCY CARD**

SPORT		
LAST NAME (PRINT) _____	FIRST _____	MI _____
Address _____	BIRTH DATE _____	GRADE _____
Father's Name _____	Home Phone# _____	
Mother's Name _____	Bus.# _____	
	Bus.# _____	

**EMERGENCY TELEPHONE NUMBERS - LIST TWO (2)**

- 1) Print Name \_\_\_\_\_ Telephone \_\_\_\_\_
- 2) Print Name \_\_\_\_\_ Telephone \_\_\_\_\_

**PLEASE LIST ANY MEDICAL CONDITIONS**

Chronic Illness \_\_\_\_\_ Allergies (antibiotics, bites, etc.) \_\_\_\_\_  
Medications (regularly taken) \_\_\_\_\_ Dental Appliances/abnormalities \_\_\_\_\_  
Protective Eyewear/Contact Lenses \_\_\_\_\_ Last Tetanus \_\_\_\_\_ Other \_\_\_\_\_

Date of Signature \_\_\_\_\_ Parent's Signature \_\_\_\_\_

**APPROVED TO PARTICIPATE**

\_\_\_\_\_  
Signature—Athletic Director

\_\_\_\_\_  
Signature—School Nurse