SOLVAY UNION FREE SCHOOL DISTRICT – ***Interscholastic Athletics Medical and Eligibility Certification***
(PLEASE PRINT)

Name: ______________________________ Birthdate: ____________ Age: ________

Address: ______________________________ Sex (circle) M F Grade: ________

Phones: Home: ______________________ Emergency ____________ Date entered 9th grade: ____________

Father's/Guardian Name: ______________________ Place of Employment: ____________ Phone: ________

Mother's/Guardian Name: ______________________ Place of Employment ____________ Phone: ________

Transfer Student Only: From (Name of School) ______________________________

Sport & Season: Fall: ______________ Winter: ______________ Spring: ______________

(do not write in shaded space below)

Date of last approved sports physical: ______________ School Nurse's Signature: ______________

Restrictions: (Circle one) None or ______________________________

Dear Parent:
We need the following information in order to reach you quickly if your child should be hurt or become ill and in order that our school health records may be more complete. Please fill out this form and return to the school.

Has you child received any immunizations or test not previously reported? If so, please write name and date: ______________

Is there anything concerning the health of your child which the coach should know in order to give your child special care? ______________

IN THE EVENT YOU CANNOT BE REACHED IN AN EMERGENCY, PLEASE GIVE THE FOLLOWING INFORMATION (OTHER THAN PARENT):

Name: ______________________ **Address:** ______________________ **Phone:** ______________

Family Doctor : ______________________ **Address:** ______________________ **Phone:** ______________

In the event of an extremem emergency and none of the above mentioned people can be contacted, we will call an ambulance. Your signature below is consent to this policy.

Parent's or Guardian's Consent: ______________________________