Summit Hill School District 161
Administration Center
20100 S. Spruce Drive Frankfort, IL 60423
Office: 815.469.9103 Fax: 815.469.0566 www.summithill.org

# *Athletics Eligibility Form*

***All Sections, including exam by physician on reverse side, must be completed and signed in order for a student to tryout or participate in a sport. The exam is valid for one calendar year.***

## *Section 1: To be completed and signed by Parent or Guardian*

Student's Full Name: _____ Birthdate: _____ Grade: _____
Address: _____ Home Phone: _____
City/State/Zip: _____

**Parent(s)/Guardian(s) Information**
Mother's Full Name: _____ Mother's Cell Phone: _____
Mother's Employer: _____ Employer Phone Number: _____

Father's Full Name: _____ Father's Cell Phone: _____
Father's Employer: _____ Employer Phone Number: _____

Alternate Emergency Contact:
Full Name: _____ Phone: _____
Relation to student: _____

**Student Information** (please specify the following: attach a separate sheet if necessary):
Allergies: _____ Medical Conditions: _____
Medication: _____ Physical Disabilities: _____

Please specify any special instructions (hospital, contact, etc…) in the event of an emergency: _____
_____
_____

The student has school insurance for the _____ school year.

_____
(Insurance Company Name) (Policy/Group No.)

This student is insured by my personal or employer's policy:

_____
(Insurance Company Name) (Policy/Group No.)

| Please Attach A Copy Of Your Insurance Card(s) If Possible |
|---|

In case of an emergency, if the school is unable to contact the parent(s)/guardian(s), the undersigned gives permission to transport this student, by ambulance, to a local or the specified medical facility and to be treated by the doctors at that facility.

The school will take reasonable care and precautions to prevent accidents, but the school and/or the teachers are not responsible should an accident occur during scheduled practices or games.

I give my permission for the above named student to participate in the interscholastic sports.

Parent/Guardian Signature: _____ Date: _____

**Section II:** ***To be completed and Signed by the Physician***

| Key | |
|---|---|
| 0 | No Defect |
| √ | Slight Defect |
| X | Marked Defect |

## Illinois Elementary School Association

**PHYSICIAN'S CERTIFICATE FOR ATHLETES**

If this student transfers, this card should be sent to new school

Student's Name: _____ School: _____ Birthdate: _____

| REQUIRED | School Year 20 | RECOMMENDED | School Year 20 |
|---|---|---|---|
| MONTH-DAY | | URINE: Specific Gravity | |
| HEIGHT | | Albumen | |
| WEIGHT | | Sugar | |
| GEN. POSTURE | | Casual | |
| HEART: Murmur | | TONSILS | |
| Rhythm | | NOSE & THROAT | |
| Blood Pressure | | GLANDS | |
| RATE: Normal | | EARS: Right | |
| After 15 Hops | | Left | |
| After 2 Minutes Rest | | TEETH | |
| HERNIA | | EYES: Right | |
| LUNGS: Percussion | | Left | |
| Auscultation | | BLOOD TESTS: | |
| ORTHOPEDIC: Feet | | TUBERCULIN TESTS: | |
| Spine | | OTHER DEFECTS: | |
| CONTAGION | | | |

**In the space below, indicate Athletic Activities in which students should not participate:**

| | | | |
|---|---|---|---|
| 20 | | 1st | M.D. |
| 20 | | 2nd | M.D. |
| 20 | | 3rd | M.D. |
| 20 | | 4th | M.D. |

I have read, understand and agree to abide by the training rules outlined in the Athletic Training Rules.

Athlete Signature: _____ Date: _____

Physicians Signature: _____ Date: _____