

Summit Hill School District 161

Administration Center

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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: _____ Phone: _____ / _____

City/State/Zip Address: _____

Parent(s)/Guardian(s) Information:

Mother's Full Name: _____ Birthdate: _____ SS# _____

Employer Name: _____ Phone: _____ / _____

Father's Full Name: _____ Birthdate: _____ SS# _____

Employer Name: _____ Phone: _____ / _____

Alternate Emergency Contact: _____ Phone: _____ / _____

(Full Name)

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
(write 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

Please Continue On The Reverse Side

In case of an emergency, if the school is unable to contact the parten(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 Signature: _____ Date: _____

Section II: To be completed and Signed by the Physician

- KEY**
 O No Defect
 ✓ Slight Defect
 X Marked Defect

Illinois Elementary School Assn.
PHYSICIAN'S CERTIFICATE FOR ATHLETES

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

Name _____ School _____ Birth Date _____

REQUIRED:	20	20	20	20	RECOMMENDED	20	20	20	20
MONTH-DAY					URINE: Spec. Grav.				
HEIGHT					Albumen				
WEIGHT					Sugar				
GEN. POSTURE					Casts				
HEART: Murmur					TONSILS				
Rhythm					NOSE AND THROAT				
Blood Pressure					GLANDS				
RATE: Normal					EARS: Right				
After 15 Hops					Left				
After 2 Min.					TEETH				
HERNIA					EYES: Right				
LUNGS: Percussion					Left				
Auscultation					BLOOD TESTS:				
ORTHOPEDIC: Feet					TUBERCULIN TEST:				
Spine					OTHER DEFECTS:				
CONTAGION:									

IN THE SPACE BELOW, INDICATE ATHLETIC ACTIVITIES IN WHICH STUDENT SHOULD NOT PARTICIPATE:

- 20 _____
- 20 _____
- 20 _____
- 20 _____

EXAM BY:

- 1st : _____ M.D.
- 2nd : _____ M.D.
- 3rd : _____ M.D.
- 4th : _____ M.D.

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

Athlete Signature: _____ Date: _____

Athlete Signature: _____ Date: _____