

ATHLETIC PARTICIPATION PHYSICAL EXAMINATION FORM

Goffstown High School 27 Wallace
Road Goffstown, NH 30345 Athletic
Office 497-4841 ext. 245 Steve
Fountain, Athletic Director

A health care provider prior to athletic participation on a Goffstown High School team must complete this form. All categories must be addressed and answered to participate in a sport.

NAME: _____ DATE OF BIRTH: _____

AGE: _____ SEX: ___ M ___ F HEIGHT: _____ WEIGHT: _____ B/P _____

The student named above has been examined. The health history and immunizations have been reviewed. There are no apparent contraindications to:

_____ Full participation in competitive sports

_____ Full participation in routine school activities

_____ Limited participation as noted below

EXCEPTIONS, COMMENTS, SPECIAL CONSIDERATION:

ALLERGIES: Most recent tetanus toxoid immunizations given on: Td or Tdap (circle one)

Please Print Below

Physician's Name: _____

Address: _____

City/State/Zip Code: _____

Telephone: _____

Most recent physical examination date: _____

Physician's Signature: _____ Date: _____

PARENTAL PERMISSION TO PARTICIPATE IN CO-CURRICULAR ATHLETICS

Having read the Goffstown High School interscholastic athletic rules: I/We give consent for

Student's Name-please print _____ to participate on the

_____ team. HAVING READ THE GOFFSTOWN HIGH SCHOOL

INTERSCHOLASTIC ATHLETICS RULES, I _____

Signature of Student

agree to abide by all rules and regulations.

I/We understand that neither the Goffstown School District nor the Athletic Department assumes any financial responsibility in case of injury to my/our child. I/We understand that a school medical insurance plan is available and that it is recommended that the student enroll in the school medical insurance plan or obtain some other form of medical coverage.

I/We fully understand that my/our child is responsible for and must return any equipment or uniform issued by Goffstown High School District or make financial restitution for the same at current replacement cost. I/We understand that in case of injury, the student should report to the coach immediately. I/We understand that payment for medical treatments will be handled in one of the following ways and in this priority: Parents health insurance, other insurance carried through the school, personal payments by the parent or guardian.

Are you home-schooled? Yes ____ No ____

Are you a foreign exchange student? Yes ____ No ____

Did you attend a **different high school last year**? Yes ____ No ____

If yes, which school? _____

Have you played a team sport at Goffstown High School before? Yes ____ No ____

I/we give permission for any sports related picture taken of my/our child to be used by Goffstown High

School Athletic Department.

Date: _____

Parent/Guardian Signature: _____

RETURN FORMS ON DESIGNATED DATES BEFORE FIRST DAY OF TRYOUTS (check athletic website for dates)

-PLEASE DO NOT MAIL OR LEAVE UNATTENDED FORMS-

GOFFSTOWN HIGH SCHOOL CONSENT/PERMIT ATHLETIC DEPARTMENT COPY - please fill out all information on both copies

Last Name: _____ First Name: _____

Sport: _____ Graduation Year: _____ DOB: _____

Parent/Guardian Name _____ Home # _____ Business # _____ Cell # _____

Parent/Guardian Name _____ Home # _____ Business # _____ Cell# _____

Doctor: _____ Phone# _____

Insurance Co. _____ POL.# _____

Date last Tetanus shot: _____ Preferred Hospital _____

Any known asthma, medical condition or allergies? _____

I/We give permission for a licensed medical authority to administer first aid or for a doctor to hospitalize, secure proper treatment, order medicine, injections, anesthesia, surgery or x-rays for my/our child following an athletic injury. I/We will not hold Goffstown High School responsible for any athletic injury or repercussion from medical attention. I/We also give permission to transport my/our child to a medical facility for the purpose of obtaining medical care following an athletic injury. Every attempt will be made to contact you prior to any decisions. I agree to be financially responsible for any athletic injury and the return of all athletic equipment issued.

WE REQUEST THAT BOTH PARENTS/GUARDIANS SIGN THIS FORM

PARENT/GUARDIAN _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

Home Address: _____

GOFFSTOWN HIGH SCHOOL CONSENT/PERMIT COACHES COPY - please fill out all information on both copies

Last Name: _____ First Name: _____

Sport: _____ Graduation Year: _____ DOB: _____

Parent/Guardian Name _____ Home # _____ Business # _____ Cell # _____

Parent/Guardian Name _____ Home # _____ Business # _____ Cell# _____

Doctor: _____ Phone# _____

Insurance Co. _____ POL.# _____

Date last Tetanus shot: _____ Preferred Hospital _____

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PARENT/GUARDIAN _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

Home Address: _____