Physical, Eligibility, Permission and Insurance Form for Southaven Middle/High School Athletes

Name _____
Last First Middle

Residence (No P.O. Box Numbers Please)

Street Address_____

City/State/Zip_____

Home Phone #_____

Emergency #_____

Social Sec. #_____

Participating in following sports/activities:_____

Sex: Male or Female

Date of Birth: _____ 2013-2014 Grade_____

I give my child, _____, permission to participate in Athletics/Activities (Football, Track, Golf, Volleyball, Basketball, Band, Cheerleading, Swim, Soccer, Power-lifting, Softball, Baseball, Tennis, Cross-Country) for Southaven Middle/High School. I also give permission for my child to accompany any school team which he/she is a part of on any trip, local or out of town. I also give any coach or administrator of Southaven High School consent to allow emergency medical care which may become necessary in the course of travel or participation in athletics/activities. I also give consent for my child to receive a pre-participation physical.

Parent Signature_____

Insurance Coverage: School Policy _____
Personal Policy _____
Company Name _____
Policy Number _____

If you do not have insurance that covers your son/ daughter you must buy school insurance. This insurance will cover your son/daughter for the entire year. If you need this type of insurance, your son/ daughter can pick up a form from the athletic director. Your child will not be allowed to try out or participate in any athletic/activity without a copy of insurance card on file.

Please staple a copy of your current insurance card to this form.

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Name:_____Age:_____Dob:_____

Height_____Weight_____BP_____

Rt Eye:_____Lt Eye_____Pulse____

Pupils Equal: Yes_____No_____

Satisfactory	Yes	No
General		
Head		
ENT		
Chest		
Heart		
Abdomen		
Skin		
Extremities/Back/Neck		

☐ Passed with no restrictions.

☐ Passed with restrictions. Further evaluation should be received for the following reasons: _____
_____
_____

☐ Failed. Due to
_____
_____
_____

Health History (Parent or Guardian to fill out)

Mark Yes or No Only	Yes	no
Chronic/Recurrent illness?		
Hospitalization?		
Surgery other than tonsils?		
Injuries treated by physicians?		
Current Medications?		
Organs Missing?		
Heat exhaustion/stroke?		
Dizziness, fainting, convulsions and or headachess?		
Knocked out?		
Concussion?		
Wear glasses or Contacts?		
Hearing defects?		
Dental appliacnes Bridge/brace/cap/plate?		
Cough/Pain?		
Problems with liver, spleen, or kidney?		
Hernia?		
Recurrent skin disease?		
Bone/Joint injury? Sprain/Dislocation? Injury that cause a missed event?		
Allergy to Medications?		
Tetanus Booster in the last 10 years?		

_____
Provider Signature

_____
Provider Printed Name

_____
Date