

## SPORTS LIST

BIE

3-3-10

STUDENT	GRADE	CARD	PHYSICAL FORM	IMPACT TEST	PE Expires
ANDERSON, DYLAN	09		✓	✓	
BACHAUMARD, ENZO	09				
BEERS, TREVOR	09	✓	✓		
BEJNEROWICZ, KYLE	09		✓	✓	
CARREGAL, KEVIN	09	✓	✓	✓	
CATTARUZZA, ZACHARY	09		✓	✓	
CLYNE, CHADWICK	09	✓	✓	✓	
COOPER, DAVID	09		✓	✓	4-13-10
COSTANTINI, LAWRENCE JOSEPH	09	✓	✓	✓	
DEPATIE, ANDREW	09			✓	
DESISTO, TYLER RYAN	09		✓	✓	
DISTASIO, PAUL	09	✓	✓	✓	
ECKMAN, TIMOTHY	09		✓	✓	
EHRlich, PAUL	09		✓	✓	4-25-10
GLASSER, JARED	09	✓	✓	✓	
LISITANO, MARK	09	✓	✓	✓	
LISITANO, JOHN	09	✓	✓	✓	
LOVEJOY, BENNETT	09	✓	✓	✓	
MCDERMOTT, TRISTAN	09				
MITCHELL, DYLAN	09			✓	
RING, MICHAEL	09	✓	✓	✓	
SAUNDERS, PATRICK	09	✓	✓	✓	
SCHILLING, COLTON	09		✓	✓	
SERRA, MICHAEL	09		✓	✓	
SEVERINO, MARK	09	✓	✓	✓	6-5-10
SULLIVAN, SHAUN	09	✓	✓	✓	4-30-10
VAN DE BOVENKAMP, NICO	09				
ZUSE, TYLER	09	✓	✓	✓	
FONICELLO, SHANE	10			✓	
FULTON, ZACHARY	10			✓	
GUNN, SEAN	10		✓	✓	
KIRWIN, DAVID	10				
KNAPP, MICHAEL	10	✓	✓	✓	

MONTESI, CHRISTOPHER	10		✓	✓
NOONAN, ROBERT EMMETT	10	✓	✓	✓
PASAY, ERIC	10	✓	✓	✓
PRUSINSKI, DAVID	10	✓	✓	✓
RING, WILLIAM	10	✓	✓	✓
TOLSON, CHRISTIAN	10		✓	✓
WEBER, ANDREW	10		ⓑ	✓
WILCOX, ADAM J	10		✓	✓
CATTARUZZA, CHRISTIAN JAMES	11		✓	✓
CURRY, ETHAN THOMS	11	✓	✓	✓
DEACON, JOHN GRADY	11			
DRAKE, JORDAN A	11	✓	✓	✓
FOGARTY, KEVIN R	11	✓		
LANE, MATTHEW J	11		✓	
PETRICK, STEPHEN T	11		✓	✓
PETROWSKI, NICHOLAS JOSEPH	11		✓	
POTTER, ROBERT	11	✓	✓	
RACCUIA, TROY PETER	11	✓	✓	✓
SLADE, JAKE	11		✓	✓
CARLSON, RYAN T	12	✓	✓	✓ 4-3-10
CRICCHI, MICHAEL A	12		✓	✓ 4-12-10
DEAR, ADAM F	12	✓	✓	✓
DEPATIE, JOSEPH T	12			✓
FONICELLO, ZACKARY J	12		✓	✓ 4-5-10
GOZZI, MATTHEW	12	✓	✓	
GUNN, KEVIN P	12		✓	✓
LISITANO, JOSEPH	12	✓		✓
LORICCO, JOHN R	12			
POLASTRI, NICHOLAS A	12			✓
VAN ANTWERP, SCOTT C	12		✓	✓
VANDER WYDEN, READ R	12			✓

## ATHLETIC EMERGENCY INFORMATION

Athlete's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ Telephone no. \_\_\_\_\_  
Parent Name \_\_\_\_\_ Employer \_\_\_\_\_ Telephone no. \_\_\_\_\_  
Emergency Contact Person \_\_\_\_\_ Telephone no. \_\_\_\_\_  
Second Contact Person \_\_\_\_\_ Telephone no. \_\_\_\_\_  
Family Doctor's Name \_\_\_\_\_ Telephone no. \_\_\_\_\_  
Family Dentist Name \_\_\_\_\_ Telephone no. \_\_\_\_\_  
Date of last physical exam \_\_\_\_\_  
Hospital preference \_\_\_\_\_  
Highly allergic to: \_\_\_\_\_  
Diabetic \_\_\_\_\_ Epileptic \_\_\_\_\_ Date of last Tetanus Shot \_\_\_\_\_  
Hepatitis B Vaccine \_\_\_\_\_

\*List any injuries or illnesses, requiring medical attention, that have occurred in the last year \_\_\_\_\_

Other information that may be important: \_\_\_\_\_

To the best of my knowledge my son/daughter is physically able to participate in athletics. You have my permission to take whatever action deemed necessary for the health and welfare of my child.

Parent/Guardian Signature \_\_\_\_\_

(Please complete opposite side)

## GUILFORD PUBLIC SCHOOLS ATHLETIC PERMISSION AND WARNING FORM

Your daughter/son has expressed a desire to compete in an interscholastic sport in Guilford. A yearly physical examination and a parental permission form are required prior to athletic participation.

We (parent and student athlete) acknowledge that we have read and understand the contents of the Student Athletic Handbook and agree to adhere to these regulations.

We realize that participating in organized athletics involves the potential for injury which is inherent in all sports. We acknowledge that even with the best coaching, use of the most advanced equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis, or even death.

We have read and understand this warning and \_\_\_\_\_  
(Student-Athlete's Name)

has my permission to participate in \_\_\_\_\_ during \_\_\_\_\_ - \_\_\_\_\_  
(Sport)

Signed \_\_\_\_\_ Signed \_\_\_\_\_  
(parent or guardian) (student-athlete)

(please complete opposite side)

## GUILFORD PUBLIC SCHOOLS SPORTS PARTICIPATION HEALTH RECORD

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. **THIS SIDE MUST BE COMPLETED BY PARENT & STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ SCHOOL \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ GRADE \_\_\_\_\_  
 SPORTS BEING PLAYED (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

### MEDICAL HISTORY

(To be completed by student and parent or guardian)

1. Do you have any allergies? (Drugs, Food, Insect Stings etc.)  
 \_\_\_\_\_ YES; list: \_\_\_\_\_ \_\_\_\_\_ NO
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally)  
 \_\_\_\_\_ YES; list: \_\_\_\_\_ \_\_\_\_\_ NO
3. Are you presently being treated for any condition by a physician or other health care professional?  
 \_\_\_\_\_ YES; explain: \_\_\_\_\_ \_\_\_\_\_ NO
4. Have you ever been advised by a doctor not to participate in any sport?  
 \_\_\_\_\_ YES; explain: \_\_\_\_\_ \_\_\_\_\_ NO
5. Do you have any chronic conditions, disorders or diseases? Check those applicable or → → → → → → → → → → \_\_\_\_\_ NO

_____ Asthma	_____ Bleeding Disorders	_____ Diabetes	_____ Epilepsy (Seizures)
_____ Hepatitis (liver disease)	_____ Hypertension (High Blood Pressure)	_____ Sickle Cell Anemia	_____ (Other) _____
_____ Mononucleosis-Yr _____	_____ Kawasaki's Disease	_____ Handicap (Describe) _____	

Please check where applicable if you have or have had any of the following:

	YES	NO		YES	NO
Head injury, concussion, or been unconscious If yes, how many times _____	_____	_____	Eye injury or retinal detachment	_____	_____
Headaches more than once a week	_____	_____	Blurred vision or vision in one eye only	_____	_____
Lack of feeling or numbness in any part of the body	_____	_____	Wear glasses or contact lenses	_____	_____
Heat exhaustion or heat stroke	_____	_____	Hearing loss or impairment in one or both ears	_____	_____
Difficulty running 1/2 mile without stopping	_____	_____	Tubes in ears or a perforated eardrum	_____	_____
Chest pain, dizziness or passing out during exercise	_____	_____	False teeth, caps or braces	_____	_____
Coughing, wheezing or gasping for breath with exercise or cold weather	_____	_____	Nose bleeds for no reason	_____	_____
Smoke cigarettes or chew tobacco	_____	_____	Bruising easily or taking a long time to stop bleeding when cut	_____	_____
Heart problem, murmur or arrhythmia	_____	_____	Diarrhea more than once a week	_____	_____
Family member with a heart attack under age 50	_____	_____	Black or bloody bowel movements (stools)	_____	_____
Loss or gain of more than 10 lbs. in last year	_____	_____	Kidney disease or dark, brown or bloody urine	_____	_____
Special diet for medical reasons	_____	_____	Less than two kidneys or, in males, two testicles	_____	_____
<i>For female participants:</i>			Lump(s) in arm pit or groin	_____	_____
Absent or irregular monthly periods	_____	_____	Rash or skin problem	_____	_____
Disabling cramps with your menstrual periods	_____	_____	Neck, spine or low back injury or pain	_____	_____

Have you ever been hospitalized for medical or surgical reasons? → → → → → → → → → → → → → → → → YES NO

If yes, provide the following information:

<u>REASON</u>	<u>YEAR</u>	<u>HOSPITAL</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following bones, joints or muscles?

- |                                |                               |                                   |                                |                                  |                                    |                                |
|--------------------------------|-------------------------------|-----------------------------------|--------------------------------|----------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Head  | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Elbow | <input type="checkbox"/> Forearm | <input type="checkbox"/> Wrist     | <input type="checkbox"/> Hand  |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Back | <input type="checkbox"/> Hip      | <input type="checkbox"/> Thigh | <input type="checkbox"/> Knee    | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Ankle |
|                                |                               |                                   |                                |                                  | <input type="checkbox"/> Foot      |                                |

Please describe all items checked above, including the year the injury occurred: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

STUDENT AND PARENT OR GUARDIAN:

We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL EXAMINATION – To Be Completed By Medical Doctor or his/her designee**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**GENERAL EXAM**

DATE OF EXAM \_\_\_\_\_

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
		Arrhythmia
		Murmur
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
PHYSICAL MATURITY (TANNER STAGE)		1 2 3 4 5

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
 BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_  
 HCT/HGB \_\_\_\_\_  
 URINALYSIS: \_\_\_\_\_ Protein \_\_\_\_\_ Blood \_\_\_\_\_ Glucose \_\_\_\_\_  
 VISUAL ACUITY: \_\_\_\_\_ RIGHT \_\_\_\_\_ LEFT  
 CORRECTED TO: \_\_\_\_\_ RIGHT \_\_\_\_\_ LEFT  
 HEARING: \_\_\_\_\_

BODY FAT (Optional) = \_\_\_\_\_ %  
 CHOLESTEROL (Optional) = \_\_\_\_\_

LAST TETANUS BOOSTER Date: \_\_\_\_\_  
 LAST MEASLES (MMR) BOOSTER Date: \_\_\_\_\_  
 OTHER IMMUNIZATIONS \_\_\_\_\_ Date: \_\_\_\_\_

SUMMARY: \_\_\_\_\_

**ORTHOPEDIC EXAM**

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS/HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

**RECOMMENDATIONS**

WEIGHT LOSS/GAIN \_\_\_\_\_ MEDICATIONS \_\_\_\_\_  
 STRENGTHENING \_\_\_\_\_ SPECIAL EQUIPMENT \_\_\_\_\_  
 STRETCHING \_\_\_\_\_ BRACING/TAPING \_\_\_\_\_  
 CONDITIONING (Endurance) \_\_\_\_\_

I certify that on this date, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:

\_\_\_\_\_

\_\_\_\_\_

Signature of Medical Doctor or his/her Designee \_\_\_\_\_ M.D. \_\_\_\_\_ Date of exam \_\_\_\_\_ Telephone \_\_\_\_\_ Medical Doctor (Print or Stamp) \_\_\_\_\_

This form was developed and approved by: Connecticut Chapter, Committee on Sports Medicine - American Academy of Pediatrics  
 Connecticut Chapter, Committee on School Health - American Academy of Pediatrics  
 The Connecticut State Medical Society Committee on the Medical Aspects of Sports