FRONTIER CENTRAL ATHLETIC DEPARTMENT

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Please answer ALL the following questions to help us provide the best possible care for your child in case of injury while participating in interscholastic activities at Frontier Central.

Name of Student: _____ Grade: _____

School: _____ Sport: _____ DOB: _____
Parent's Name: _____
Home Address: _____ Home Phone: _____
Father's Work Number: _____ Cell Number: _____
Mother's Work Number: _____ Cell Number: _____
Friend/Relative (Emergency Contact) Name: _____
Home Number: _____ Cell Number: _____
Medical Provider: _____

Authorization:

Frontier Central School District contracts a certified *athletic trainer* for coverage of school athletics. This athletic trainer is qualified to assess, treat, and recondition most injuries your son or daughter may incur while participating in the school's athletic programs.

The certified athletic trainer's qualifications include: certification by the National Athletic Trainers Association, registration/licensure with the New York State Education Department, certification in CPR for the professional responder and first aid, and a minimum of a Bachelor of Science degree in the sports medicine field.

***I give my permission for the Certified Athletic Trainer to assess, treat and/or recondition my son or daughter.**
***In case of emergency, if I cannot be reached, I authorize my child to receive emergency treatment, including treatment by a doctor other than our medical provider.**
Parent Signature: _____
Date: _____

ALL FORMS MUST BE SIGNED BY PARENT/GUARDIAN NO SOONER THAN 30 DAYS BEFORE THE START OF SPORTS.

Richard L Gray

Frontier Falcons
Sports Candidates Questionnaire

	YES	NO		YES	NO
Allergies/ Hay Fever			Headaches		
Bee Sting			Head Injury/Concussion		
Asthma			Heart Problems/Murmur/Chest Pain		
Anemia			Nose Bleeds Frequent/Severe		
Arthritis			Bladder/Kidney Problem/Injury		
Ankle Injury			Back Injury		
Convulsions/Seizures			Fracture/Dislocation Bones/Joints		
Fainting Spells			Knee Pain/Injury		
Diabetes			Neck Injury		
Ear Problems/Hearing Loss			Nose Fracture		
Eye Problems/Vision Loss			Rheumatic Fever		
Injury To Spleen			Stomach Ulcer		
Joint, Muscle, Ligament Tear, Sprain			Bleeding Disorder		
Wears Contacts/Glasses			Lung Problems		
Elevated Blood Pressure			Other		

Is there a family history of sudden death from heart disease at a young age?		
Has your child had an illness within the past year since last physical requiring medical attention, which may hinder sports participation example: diabetes, hyperactivity, surgery		
Has your child taken any medication in the past year?		
Is your child taking any medication now?		
Is your child under physicians care now?		
Has your child had a surgical operation?		
Do you have any worries about your child's health or other questions you would like to discuss?		

If you have checked YES to any of the about questions, please explain in the space provided:

_____

_____

_____

_____

Parental Permission: I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate on the athletic team named on the front part of this form. I understand that in order to best meet the needs of the athlete, relevant health information may need to be shared with the coach or athletic trainer. The answers are correct as of this date and he/she has my permission to participate.

Date_____ Parent/Guardian Signatures: _____

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