

**COVENTRY PUBLIC SCHOOLS**  
**SPORTS CANDIDATE QUESTIONNAIRE**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Physical: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Work/Cell Number: \_\_\_\_\_

This form must be signed by a parent/guardian. Please check YES or NO. If response is YES, explain in the space at the lower portion of this page or on the back of this form.

- | <i><b>Does the student:</b></i>   | <u><b>YES</b></u>        | <u><b>NO</b></u>         |
|---|--------------------------|--------------------------|
| <b>1. Have any life threatening allergies that require an EpiPen</b>        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Take any long-term continuous medication?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>3. Have a seizure disorder?</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Wear glasses/contact lenses during play?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have only one eye or eye disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have false teeth, wear braces, need a mouth guard?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have only one kidney or a kidney disease?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>8. Have diabetes, hypoglycemia</b>                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>9. Have easy bleeding when bruised/does it take a long time to stop?</b> | <input type="checkbox"/> | <input type="checkbox"/> |

- | <i><b>Has the student ever had?</b></i>   | <u><b>YES</b></u>        | <u><b>NO</b></u>         |
|---|--------------------------|--------------------------|
| 10. Family history of early cardiovascular or sudden unexplained death?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Previous or current history of heart/cardiovascular disorder?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Fainting/loss of consciousness or lightheadedness during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. A concussion (knocked unconscious)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. A serious eye injury, ear injury, or surgery?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>15. Asthma, high blood pressure, or heart problems?</b>                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Liver disease or had any injury to his/her spleen?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. "Mono" (mononucleosis)? Year _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Back pain/pinched nerves or a neck or spine injury?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. A sprained knee or water on the knee?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Pain underneath the kneecaps or wear a brace?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Shin splints?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Ankle or foot problems, including sprains?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Joint problems (shoulder, wrist, elbow, etc.) or Arthritis                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. A fracture (broken bone)? If yes, specify below:                            | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Area Fractured</u> <u>Year</u> <u>Area Fractured</u> <u>Year</u>             |                          |                          |

Explain YES answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Parent/Guardian Consent**

I hereby give my consent for the above-named student to: (1) represent his/her school in athletic activities, provided that such athletic activities are approved by the State Association; and (2) to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel. If the student has had a major illness or has been injured since the last physical, documentation will be required from their physician before participation is allowed

**NOTE:** This form is to be filled out completely and filed in the Athletic directors office or with the appropriate coach before the student is allowed to try-out, practice, or compete \* **If your student Requires Emergency Medication (Asthma Inhalers, EpiPen & Benadryl for Anaphylaxis) a copy of the physicians order must be provided to the coach prior to Try-outs. Diabetic Students must be able to self manage their care, or the parent must be present. Medication provided to the coach shall be separate from what is stored in the nurse's office.**

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)