

**Califon Public School**

6 School St. Califon, NJ 07830 Phone 908-832-2828 fax 908-832-6719

**RECERTIFICATION  
INTERSCHOLASTIC SPORTS FORM**

Student \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phones: Mother \_\_\_\_\_ Father \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Employer \_\_\_\_\_ Phone: \_\_\_\_\_

If unable to contact parent:  
Alternate Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENT/GUARDIAN PERMISSION**

I understand my son/daughter desires to participate in \_\_\_\_\_ on the Califon School Team.  
(name of sport)

Realizing that such activity involves the potential for injury which is inherent in all sports, I acknowledge that even with the best coaching, use of the most advanced protective 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. I have read and understand this warning and hereby give permission for my son/daughter to play \_\_\_\_\_.  
(name of sport)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY TREATMENT**

In case of emergency or serious illnesses, I request that I/we be contacted. I hereby give permission for emergency medical treatment that will include, but not limited to, initial diagnostic x-rays and other such procedures as the physician may see as necessary for the preservation of health. I realize that the school cannot assume responsibility for the payment of medical fees or expenses incurred.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**SPORTS HEALTH HISTORY**

- |  |     |    |
|--|-----|----|
| 1. Has been advised not to participate in any sport.....                         | Yes | No |
| 2. Is under a physician's care for injury/illness/hospitalization.....           | Yes | No |
| 3. Has experienced loss of consciousness after an injury .....                   | Yes | No |
| 4. Has experienced a fracture or dislocation.....                                | Yes | No |
| 5. Has undergone any surgery.....  | Yes | No |
| 6. Takes any medication on a regular basis.....                                  | Yes | No |
| Name(s) Reason(s) _____  |     |    |
| 7. Has allergies (I.E. hives, asthma, and/or reaction to bee stings).....        | Yes | No |
| 8. Has experienced frequent chest pains or palpitations.....                     | Yes | No |
| 9. Has a recent history of fatigue and undue tiredness.....                      | Yes | No |
| 10. Has history of fainting with or without exercise.....                        | Yes | No |
| 11. Has a history of a family member with sudden death.....                      | Yes | No |
| 12. Convulsive disorder.....   | Yes | No |
| 13. Vision of less than 20/20 in either eye .....                                | Yes | No |
| 14. Has a history of asthma or unusual shortness of breath with exercise.....    | Yes | No |
| 15. Concussion, fainting or head injury.....                                     | Yes | No |
| 16. History of a problem with his/her neck, back, knees or other joint .....     | Yes | No |
| 17. Diabetes.....  | Yes | No |
| 18. Fracture or severe sprain or strain.....                                     | Yes | No |
| 19. Anemia or bleeding tendency.....   | Yes | No |
| 20. Will wear: Eyeglasses ___ Contact lenses ___ (hard or soft) for sports ..... | Yes | No |

Please explain "Yes" answers:

I certify that the above history is accurate: \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Signature