

CHASE COLLEGIATE SCHOOL

565 Chase Parkway,
Waterbury, CT 06708

*required for all new students, all middle & upper
school students and students in preK, K and 3rd grade*

PHYSICAL EXAMINATION

please return directly to nurse's office
by August 15, 2010

Name: _____ Male _____ Female _____ Date of Birth _____ Grade _____

Address: _____ Town: _____

Parent/Guardian Name: _____ Home Phone: _____

PARENT OR GUARDIAN'S PERMISSION AND RELEASE

I hereby give permission for the above named student to represent his/her school in athletic activities except those indicated on this form provided that such athletic activities are approved by Chase Collegiate School (the School). I also give my consent for the student to accompany the School team on any of its local or out-of-town trips.

I realize that anyone who participates in athletic activities in which the body and/or objects are in motion is exposing themselves to a risk of severe injury, paralysis or even death, regardless of the use of protective equipment, the utilization of standard coaching techniques and the observance of the rules, these injuries can still occur. Acknowledging the aforesaid factors and realizing that the School, its Trustees, or its agents/employees have no responsibility to provide first aid at any athletic activity, the parent/guardian understands that the risk of injury is assumed by the parent and student when they sign this form. However, in the event physicians, physical therapists, physician assistants, nurses or other persons trained in rendering of first aid are available, as volunteers or otherwise, and render first aid to any student injured during the course of any such activities, then the parents do hereby release and forever discharge such persons and the School, its Trustees, or its agents/employees from any liability arising out of any first aid or immediate treatment of injuries.

In the case of an emergency situation, where neither myself nor the emergency contacts identified are able to be reached, I hereby delegate authority to Chase Collegiate School personnel to make decisions of a medical/surgical nature for the health and physical welfare of my child. I understand that my family insurance plan is the first carrier in the event of medical expenses.

Signature of Parent/Guardian _____ Date: _____

Work and/or Cell Phone Number(s): _____

Emergency Contact: _____ Phone: _____

HEALTH HISTORY - to be completed by parent and/or student before being brought to doctor's office

1. Do you have any ALLERGIES (medications, food, insect stings, etc.)? _____ YES _____ NO

If yes, please list: _____

2. Are you currently taking any medications, daily or occasionally? _____ YES _____ NO

If yes, please list: _____

3. Are you presently being treated for any condition by a physician or other health care professional? _____ YES _____ NO

If yes, please list: _____

4. Do you wear a hearing aid, glasses/contacts, false teeth, caps or braces or use a mouth guard? _____ YES _____ NO

If yes, please list: _____

5. Do you have any chronic conditions/disorders? Check those that apply or NONE: _____

- ___ Anemia ___ Bleeding disorder ___ High blood pressure ___ Seizures
- ___ Arthritis ___ Diabetes ___ Impaired vision/hearing ___ Severe eye/ear injury
- ___ Asthma ___ Hepatitis ___ Low blood sugar ___ Other, explain: _____

6. Have you ever been hospitalized for medical or surgical reasons? _____ YES _____ NO

If yes, please give reason and year: _____

7. Please check if you have or have had any of the following:

YES	NO	YES	NO
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

