

Season (circle): Spring
Fall

Summer
Winter

RIRA

Athlete Name: _____

Sport Candidate and Permission Form

All questions must be answered by the parent/guardian with the athlete. It must be completed each registration since problems with health can arise at any time. *Please make sure you review any positive responses with your physician to make sure it is safe for your student-athlete to participate in Pittsford Crew. In the last THREE YEARS, has your athlete had**:*

Injury or illness since last check-up?	Y	N	Any special equipment or devices required for you to participate?	Y	N	Use of glasses, contact lenses, braces, retainers or dental bridges?	Y	N
Hospitalization or surgeries?	Y	N	Any skin conditions?	Y	N	Diabetes?	Y	N
Any chronic medications or supplements? List below if yes.	Y	N	Concerns about weight, lose weight regularly for your sport?	Y	N	Thyroid disease?	Y	N
Allergies to medications, insects, food, latex?	Y	N	Missing organ (eye, kidney and/or testicle)?	Y	N	Bleeding disorders or Sickle Cell Disease?	Y	N
Chronic cough, wheezing, trouble breathing or asthma?	Y	N	Broken bones, joint injuries, muscle or tendon problems?	Y	N	Severe menstrual difficulties?	Y	N
Chest pain with exercise?	Y	N	Numbness/tingling in extremities or pinched nerve?	Y	N	Learning Disability or ADD/ADHD?	Y	N
History of high blood pressure or heart problems?	Y	N	Any mental health issues (depression, anxiety, OCD, eating disorders, etc.)?	Y	N	Seizure, unconsciousness, or concussion?	Y	N
Heart racing or skipped heartbeats?	Y	N	Frequent and/or severe headaches?	Y	N	Problems with exercising in the heat?	Y	N
Sudden death in a close relative <50 years old?	Y	N	Dizziness or fainting with exercise?	Y	N	Other chronic or recurrent medical problems?	Y	N

****Please provide an explanation for any question answered “yes” below and on the back of this form if necessary. Include dates and details of injuries and illnesses.**

MEDICATIONS: List all medications and dosages. If medications are taken “prn,” please indicate how often they are used. Use the back of this form if necessary. Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication	Dose	Frequency	Check if “as needed”	Reason for Med	Check if Temporary

Parent/Guardian: I have carefully read and reviewed the above with my child. To the best of my knowledge, there is no existing condition that should exclude my child from participating in Pittsford Crew. I hereby give permission for my child to participate in Pittsford Crew this season. I give permission to share my child’s medical information with coaches and appropriate supervisory Pittsford Crew personnel. I give permission for Pittsford Crew Coaches and supervisory personnel to seek medical attention for my child in an emergency situation. I understand that Pittsford Crew does not assume responsibility for lost or broken corrective lenses or orthodontic devices.

Parent Signature: _____ **Date:** _____

Parent Name Printed: _____