

**PATRIOTS CHEER SQUAD
PHYSICAL CONDITION AND PARENTAL CONSENT FORM**

Name _____ Date of Birth _____

Home Address _____ Phone _____

Personal Physician _____ Phone _____

In case of emergency contact _____

Relationship _____ Contact phone _____

Explain yes answers on the back of this page. Circle questions you don't know the answer to.

		Yes	No
1	Do you have an ongoing chronic illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you currently taking any prescription or nonprescription medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
3	Do you have any allergies (for example, to pollen, medicine, food, or insect bites)?	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6	Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you have any current skin problems such as itching, rashes, fungus or blisters?	<input type="checkbox"/>	<input type="checkbox"/>
8	Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9	Have you had a severe viral infection such as myocarditis or mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you ever had racing of the heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
11	Have you ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12	Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
13	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
14	Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
15	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
16	Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
17	Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
18	Have you ever been dizzy during or before exercise?	<input type="checkbox"/>	<input type="checkbox"/>
19	Has a physician ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
20	Do you use any special protective or corrective equipment or devices that aren't usually used for cheerleading (For example, knee brace, special neck roll, foot orthotics, retainer on your teethe, hearing aid, eye glasses)?	<input type="checkbox"/>	<input type="checkbox"/>
21	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
22	Record the date of your last Tetanus shot _____		

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son becomes ill or is injured, necessary medical care can be instituted by physicians, trainers or other personnel properly trained.

Signature of parent/guardian _____ Date _____

Signature of athlete _____ P608