CITY SCHOOL DISTRICT OF NEW ROCHELLE
515 NORTH AVENUE
NEW ROCHELLE, NEW YORK 10801-3416

HEALTH SERVICES DEPARTMENT

TEL: (914)576-4264 FAX: (914)632-3371

SPORTS PHYSICAL REQUIREMENT

The physical exam form submitted for your child,

_____, requires additional documentation for your child to be eligible to participate in the City School District of New Rochelle's sports program.

The sports clearance attestation form below must be signed by both the provider and the parent/guardian prior to your child being eligible to try-out for or participate in the New Rochelle Sports program. Please return this form to the _____School Health Office

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: _____ ❒ None

❒ **Known or suspected disability:** _____ ❒ Please monitor

❒ **Restrictions:** _____ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: _____

SPORTS CLEARANCE : By signing and submitting this form, the parent and physician attest that they have fully disclosed all of this student's health history, conditions, medications and relevant family history (e.g., early cardiac death.) Parent and physician assume liability for non-disclosures of such information. The School District Physician has final authority to medically clear students for interscholastic sports participation. Parental signature authorizes School Health personnel to communicate with your child's physician regarding medical clearance for sports.

Provider's Signature: _____ **Phone:** _____

Provider's Name/Address: _____ **Fax:** _____

Parent Signature: _____ **Date:** _____