

**ST. LOUIS UNIVERSITY HIGH SCHOOL**  
**FRESHMEN STUDENT HEALTH RECORD AND**  
**APPLICATION TO PARTICIPATE IN INTERSCHOLASTIC ACTIVITIES/ATHLETICS**

**\*\*PHYSICALS MUST BE IN THE MEDICAL OFFICE BY 08/07/09.\*\***

**COACHES AND/OR MODERATORS WILL NOT BE ABLE TO ACCEPT THE PHYSICALS!**

**\*PHYSICALS FOR 09-10 SCHOOL YEAR MUST BE DATED AFTER APRIL 1, 2009.\***

**PRINT INFORMATION**

NAME \_\_\_\_\_  
(last) (first) (middle initial)

ADDRESS \_\_\_\_\_  
(street address) (city) (state) (zip code)

PHONE \_\_\_\_\_  
(home) (father's work #) (mother's work #)

DATE OF BIRTH \_\_\_\_\_  
(month) (day) (year)

Our son is covered by health insurance for the current school year with

\_\_\_\_\_  
(name of insurance company) (policy number)

**APPLICATION TO PARTICIPATE IN INTERSCHOLASTIC ACTIVITIES/ATHLETICS**

**STUDENT'S APPLICATION**

This application to represent St. Louis University High School in interscholastic activities/athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand SLUH's Drug Policy and the eligibility standards that I must meet to represent St. Louis University High School and that I have not violated any of them.

Date \_\_\_\_\_ Signature of Student \_\_\_\_\_

**PARENT'S OR GUARDIAN'S PERMISSION**

We hereby give our consent for the above named student to represent St. Louis University High School in interscholastic activities/athletics. We also give our consent for him to accompany the team as a member on its trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice of an interscholastic contest. We also give consent and authorize the school to obtain, through a physician of its choice, such medical care as is reasonably necessary for the welfare of the student, if he is injured in the course of school activities and we cannot be reached. Finally, we agree to administration, by the school nurse, of Tylenol, Ibuprofen, Antacids, Neosporin, and emergency Epinephrine as deemed necessary for management of symptoms associated with injury or illness.

We further state that we have completed that part of this record which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment, and we certify that it is correct and complete. We have read the SLUH Drug Policy for athletes and discussed it with our son.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he has basic athletic insurance coverage.

Date \_\_\_\_\_ Signature of Parent(s) or Guardian(s) \_\_\_\_\_

**Mall to:** SCOTT GILBERT R.N., BSN  
ST. LOUIS UNIVERSITY HIGH SCHOOL  
4970 OAKLAND AVE.  
ST. LOUIS, MO. 63110

**(OVER)**

**FOR THE PHYSICIAN TO COMPLETE:**

Pulse \_\_\_\_\_ Rhythm \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Heart (check) \_\_\_\_\_ Describe any abnormality \_\_\_\_\_

Eyes/Ears/Nose/Throat (check) \_\_\_\_\_ Describe any abnormality \_\_\_\_\_

Lungs (check) \_\_\_\_\_ Describe any abnormality \_\_\_\_\_

Abdomen (check) \_\_\_\_\_ Describe any abnormality \_\_\_\_\_

Hernia: No \_\_\_\_\_ Yes \_\_\_\_\_ Genitalia \_\_\_\_\_ Reflexes \_\_\_\_\_

Extremities and back. Please indicate any history of orthopedic defect(s) \_\_\_\_\_

Urinalysis \_\_\_\_\_ (if indicated) Blood Count \_\_\_\_\_ (if indicated) **ALLERGY ALERT** \_\_\_\_\_

**PHYSICIAN'S COMMENTS ON ANY ABNORMALITIES, SIGNIFICANT PAST ILLNESS OR INJURY AND REMARKS ABOUT STUDENT'S GENERAL HEALTH:**

I certify that I have on this date examined the above named student and from this limited examination, he is approved to participate in supervised athletics and the school's physical education program.

DATE OF EXAMINATION \_\_\_\_\_

SIGNED \_\_\_\_\_ M.D. OFFICE PHONE \_\_\_\_\_

**FOR THE PARENT(S) TO COMPLETE:**

Is there any special medical concern to which the Director of Health should be alerted? Is there any specific physical, emotional, or learning disability to which the Director of Health should be alerted? **If yes, please write them below and attach a letter describing the Health Care Professional's recommendation(s):**

**IMMUNIZATION RECORD**

Please fill in **ALL OF THE DATES** when the student received the following vaccines:

**DTP (diphtheria, whooping cough, tetanus) VACCINE**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**HEPATITIS B**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**DT or TD (tetanus, diphtheria)**

- 1. \_\_\_\_\_

**ORAL POLIO DRINKS**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**MEASLES, MUMPS & RUBELLA**

(measles must have 2 doses)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

If your son had measles or rubella disease, the State law requires written certification from a physician. Attach such a note from a physician if your son **DID NOT** receive the vaccines because he had the disease.

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**PHYSICAL FORM CHECKLIST: SIGNATURES, INSURANCE INFORMATION, AND CURRENT IMMUNIZATIONS.**