

1. HISTORY OF IMMUNIZATION **REQUIRED BY MISSOURI STATE LAW**

Please attach a COPY of child's permanent immunization record from your health care provider or previous school. Month, day and year must be provided for all immunizations received, including infant series.

2. HISTORY OF ILLNESS Enter the year in which your child had the following:

CHICKEN POX _____	RUBELLA _____	MEASLES _____
MUMPS _____	SCARLET FEVER _____	STREP THROAT _____
RHEUMATIC FEVER _____	MENINGITIS _____	DIABETES _____
HEPATITIS (JAUNDICE) _____	PNEUMONIA _____	ASTHMA _____
TUBERCULOSIS _____	SEIZURE DISORDER _____	ANEMIA _____

3. HEALTH INFORMATION

Please list any allergies, injuries, operations, serious illnesses, heart conditions, vision problems, hearing loss, and any other health information you feel would be helpful:

\_\_\_\_\_  
\_\_\_\_\_

Dental (dental bridges, false teeth, etc.) \_\_\_\_\_

Is your child on medication at home or school? NO \_\_\_ YES \_\_\_

Specify name of medication(s), dosage, reason prescribed:

\_\_\_\_\_

Is your child currently under medical care? NO \_\_\_ YES \_\_\_

Specify:

\_\_\_\_\_

NOTE: PHYSICIAN TO COMPLETE SECTION 4

**MSHSAA PARTICIPATION CERTIFICATE** - Parent/Student  
(Missouri State High School Activities Association)

Section 1. **Athlete's application and personal information**

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the citizenship standard set by the school or if I am ejected from an interscholastic contest because of any unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate, which requires me to list all previous injuries or additional conditions that are known to me, which may affect my performance in so representing my school, and I verify that it is correct and complete.

\_\_\_\_\_  
**Signature of Student**

\_\_\_\_\_  
**Date**

**Section 2. Parent permission and authorization for treatment**

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be en route to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a part, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give consent for the school to obtain through a physician or hospital of its choice such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We understand that the school may not provide transportation to all events, and **permit / do not permit** (*circle one*) my child to drive his/her vehicle in such a case.

We further state that we have completed that part of this certificate, 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.

The MSHSSA By-Laws provide that a student shall not be permitted to practice or compete for a school unit until it has verification that he/she has basic athletic insurance coverage. Our son/daughter is covered by basic accident insurance for the current school year with

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**(Name of Insurance Company)**

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**(Policy No.)**

**Signatures of Parents/Guardians (all parents or guardians must sign.)**

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Date

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Date

**PARKWAY SCHOOL DISTRICT**  
(Grades 9 through 12)

*Dear Parent/Guardian:*

*Physical examinations are recommended upon entrance into school and at the beginning of the 3rd, 6th, and 9th grades. The Missouri State High School Activities Association **requires** a yearly physical examination prior to participation in inter-scholastic athletics in grades 9 through 12.*

*So much of your child's success and happiness in school and in life are dependent upon his/her physical and mental health that we are confident this information is vital in providing the best school life for your child. We shall appreciate your cooperation in this important matter.*

*Robert Malito, Ph.D.  
Superintendent*

REPORT OF PHYSICAL EXAMINATION  
and/or MSHSSA PARTICIPATION CERTIFICATE

School \_\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father/Guardian \_\_\_\_\_

Employer of Father/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Mother/Guardian \_\_\_\_\_

Employer of Mother/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Parkway School District Form # 208S (Rev. 7/01/04)

PHYSICIAN TO COMPLETE THIS SIDE

4. PHYSICAL FINDINGS:

Height _____	Weight _____	Pulse _____
Blood Pressure _____	Nutrition _____	Anemia _____
Skin _____	Scalp _____	Teeth _____
Gums _____	Nose _____	Throat _____
Tonsils _____	Enlarged _____	Diseased _____
		T & A _____
Ears _____	Eyes _____	Heart _____
Lymph Glands _____	Lungs _____	Posture _____
Orthopedic _____	Scoliosis _____	Abdomen _____
Genitalia _____	Reflex _____	Diabetic _____
Urine _____	Hernia _____	Other _____

Significant Concerns: \_\_\_\_\_

Do Immunizations comply with Missouri State Law? YES \_\_\_ NO \_\_\_

Can student carry a full program of schoolwork? YES \_\_\_ NO \_\_\_

Should physical activity at school be restricted? YES \_\_\_ NO \_\_\_

If YES please state to what extent and for how long.

\_\_\_\_\_

FOR INTERSCHOLASTIC ATHLETICS ONLY

Based on the limited examination above, this student \_\_\_\_\_ may \_\_\_\_\_ may not participate in supervised athletics.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date of examination