



Norwalk River Rowing Association

Sports Medical Authorization / Parent's Form

Valid for ONE YEAR only. From date of examination. To be completed by parent.

Athlete's Name: Last First

Address:

City State: Zip:

Phone: Year of Graduation:

Date of Birth:

TO BE COMPLETED BY PARENT Please check. (Health history)

Asthma Rx Inhaler Yes No

Diabetes Rx

Seizures Rx

Cardiac:
Student Athlete:

Fainting, dizzy spells:

Epi-Pen: Yes No

Family history: (e. g. heart attacks, death under 50)

Significant allergic reactions:Rx

Significant injury in the last 12 months: (e. g. concussion, fractures, surgery.)

Other significant medical history:

Parents please return completed Parent's and Physician's forms to:

Norwalk River Rowing Association
PO Box 2084, Norwalk, CT. 06852 Attn: Youth Program Director

Parent or Gaurdian signature:



Norwalk River Rowing Association

Sports Medical Authorization / Physician's Form

Valid for ONE YEAR only. From date of examination. To be completed by physician.

| | | | | | |
|--|---------------------------------|-----------------------------------|-------------------|---------------------------------|-----------------------------------|
| HT | WT | | BP | Vision | |
| Contacts: | | | Hearing | | |
| Skin | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Musculoskeletal | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Head | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Spine / Scoliosis | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Eyes | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Neck | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| ENT | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Shoulders | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Heart | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Hand / Arms | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Lungs | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Hips | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Abdomen | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Knees | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Genitalia | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Ankles | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Neurological | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | Feet | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Comments: | | | | | |
| I certify that _____ is able to participate in interscholastic sports as of _____ (Date of Exam) | | | | | |
| Physician's Signature: | | | | | |
| Physician's Name: | | | | | |
| Address: | | | Phone: | | |

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