

ARCHDIOCESE OF SAN ANTONIO

Physician's and Parent's Certificate for Athletics

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_

PHYSICIAN'S REPORT

Height \_\_\_\_\_ Weight \_\_\_\_\_ Body Type \_\_\_\_\_

Eye \_\_\_\_\_ Ear \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Hearing \_\_\_\_\_

Heart \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Lungs \_\_\_\_\_

Joint Function: Shoulders \_\_\_\_\_ Elbows \_\_\_\_\_ Hips \_\_\_\_\_ Knees \_\_\_\_\_

Dental (Cavities, Bridges, False Teeth, Retainer, Appliance) \_\_\_\_\_ (Circle defect)

Other \_\_\_\_\_

Genitourinary \_\_\_\_\_ Hernia \_\_\_\_\_

Is student taking any medications routinely? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_

I hereby certify that on this date I have examined the above named student as indicated by items checked and recommend him/her as being physically able to participate in all the supervised activities listed with the EXCEPTION of those circled below:

- BASEBALL
- BASKETBALL
- CHEERLEADING
- CROSS COUNTRY
- FOOTBALL
- SOCCER
- SOFTBALL
- TENNIS
- TRACK & FIELD
- VOLLEYBALL

Date \_\_\_\_\_ Signature of examining Physician \_\_\_\_\_

\*\*\*\*\*DO NOT DETACH \*\*\*\*\*DO NOT DETACH \*\*\*\*\*

I hereby give permission for the above named student to compete in Archdiocesan approved sports, and go with the coach or other school representative on any trips. The parent herewith grants permission for school employees to secure medical services for the above named student if necessary. The undersigned agrees to be responsible in the safe return of all athletic equipment issued by the school to the above named student.

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

Evidence of Student Insurability:

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_