PARTICIPATION HEALTH SCREENING

Required annually in addition to school physical

Student Name _____ Grade _____

Home Address _____

Phone _____ Parent's W _____ Cell _____

Student Soc. Sec. Number _____ DOB _____

Father's Name _____ Mother's Name _____

MEDICAL CONCERNS/RESTRICTIONS

_____

_____

CURRENT MEDICATIONS

_____

I understand a sports health screening is necessary for my child's participation in _____ Catholic School Extra-curricular Sports Program.

I further understand that competitive athletics may result in injury although the school and will do all it can to reduce the risk of injury. I request _____ Catholic School representative to obtain medical treatment for my child in the unlikely event of injury or illness during practice or games and I agree to pay any expenses incurred for such treatment.

SIGNATURE OF PARENT/GUARDIA _____

JOINT Custodial PARENT SIGNATUI _____

EXAMINING PHYSICIAN'S CERTIFICATE

I hereby certify that I have examined _____ on the date indicated below. Based on the past health history s/he has given me and on my physical examination I find this athlete physically able to participate in interscholastic sports.

Any Restrictions? _____

PHYSICIANS SIGNATURE _____

DATE _____

_____ School Year