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: _____