
(STUDENT'S LAST NAME)

(FIRST)

(MIDDLE)

PHYSICIAN STATEMENT: I hereby certify that the above named student is physically fit to engage in sports.

(SIGNATURE) _____ (DATE) _____

(TITLE) _____ (STATE LICENSE) _____

Does the student have an injury or physical condition that should be watched? If yes, please list: _____

PARENTS TO COMPLETE:

If the student has health or accident insurance, other than C.I.P.F., list company name, policy number, and local claims address:

(COMPANY NAME)

(POLICY NUMBER)

(CLAIMS OFFICE ADDRESS)

I hereby give my consent for the above named student to compete in sports. I authorize the student to go with and be supervised by a representative of the school on any trips. In the event this student becomes ill or is injured, you are authorized to have the student treated and I authorize the medical agency to render treatment.

(DATE)

(SIGNATURE OF PARENT/GUARDIAN)

(OVER)

EMERGENCY NOTIFICATION- Order of Notification

In the event of an accident or emergency involving your child, school authorities place his/her welfare above all other considerations. Please list below the order of notification should a school official/doctor/hospital need to get hold of you regarding your child. (Include day and evening phone numbers.)

①Name: _____ Address: _____ Phone: _____

Relationship: _____ City: _____

②Name: _____ Address: _____ Phone: _____

Relationship: _____ City: _____

③Name: _____ Address: _____ Phone: _____

Relationship: _____ City: _____

④Name: _____ Address: _____ Phone: _____

Relationship: _____ City: _____

Additional Comments: _____

STUDENT HEALTH INFORMATION

Name Of Physician: _____ Medical Group: _____ Phone: _____

❶ Is your child being seen (currently/or in the past 6 months) by a physician? YES NO

❷ Has your child had any surgeries in the past five years? YES NO

If yes, please indicate type of surgery and approx. date: _____

❸ Does your child have a medical condition that needs to be watched by school officials? YES NO

If yes, please list the condition: _____

❹ Is your child currently taking any medication prescribed by a physician? YES NO

If yes, please list name(s) of medication : _____

❺ Will your child be taking any medication during athletic practice, games, etc. YES NO

If yes, please list name(s) of medication: _____

Please be advised that all medication taken at school and school events requires a medication form completed by a physician/dentist and parent/guardian before student can be administered medication.

Date

Signature of Parent/Guardian