PARTICIPATION HEALTH SCREENING

Required annually in addition to school physical

Student Name ____________________________ Grade ______________

Home Address ____

Phone ______________ Parent's Work _____________ 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 has and will do all it can to reduce the risk of injury. I request a _________________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/GUARDIAN ________________________________

JOINT Custodial PARENT SIGNATURE ________________________________

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