

SPORTS PHYSICAL

APPLICATION TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS

STUDENT'S NAME (LAST, FIRST, M.I.)		SCHOOL	GRADE
DATE OF BIRTH	HOME PHONE	SPONSOR'S DUTY PHONE	
<p style="text-align: center;">STUDENT'S APPLICATION</p> <p>I AGREE TO NOTIFY MY SPORTS COACH OF ANY CHANGES IN MY HEALTH STATUS, TO INCLUDE ANY MEDICATIONS I MAY TAKE OR STOP TAKING. IN ADDITION, I AGREE TO THE RELEASE OF THE BELOW INFORMATION TO THE ABOVE NAMED SCHOOL.</p>			<p>KEEP IN SCHOOL FILE</p>
DATE	SIGNATURE OF STUDENT		
<p>PARENT OR GUARDIAN PERMISSION</p> <p>I HEREBY GIVE MY CONSENT FOR THE ABOVE STUDENT TO HAVE A MEDICAL EXAMINATION (SPORTS PHYSICAL) PERFORMED BY LOCAL U.S. MILITARY HOSPITAL/CLINIC PERSONNEL, TO ENGAGE IN INTERSCHOLASTIC ATHLETICS AT THE ABOVE SCHOOL IN THE APPROVED SPORT(S) CHECKED BELOW. IN ADDITION, I AGREE TO THE RELEASE OF THE BELOW INFORMATION TO THE ABOVE NAMED SCHOOL.</p>			
DATE	PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN	

MEDICAL CERTIFICATE TO BE COMPLETED BY EXAMING PHYSICIAN

	YES	NO
Is visual correction required for competition? Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Is there a bridge or false teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are immunizations current? If no, list immunizations received.	<input type="checkbox"/>	<input type="checkbox"/>
Are there medical conditions that may affect participation? (e.g. asthma, diabetes) Please advise:	<input type="checkbox"/>	<input type="checkbox"/>
Are there medications that may be required for participation? If so, please complete medication form.	<input type="checkbox"/>	<input type="checkbox"/>

	ALL SPORTS	
	ALL SPORTS EXCEPT:	
	NO PARTICIPATION	
<p>I have examined _____ and find him/her to be physically able to compete in the supervised athletic activities checked above. This certificate is valid for one year from date indicated below.</p>		
DATE	PRINTED NAME OF EXAMINING PHYSICIAN	SIGNATURE OF EXAMINING PHYSICIAN