

St. Michael Parish School Athletics
Student Participation Physical Exam Form
*Must be received before student can practice any sport

Student Name: _____ Birth date: _____
Sex: _____ Grade: _____
Address: _____

Parent's Names: _____
Address: _____
Phone Number: _____
Family Physician: _____

Athletes History

Has this athlete ever had hospitalization, surgery, injury or serious medical illness?	Y	N
Is this athlete now under the care of a physician or taking medication?	Y	N
Should any limitations be placed on this athlete when participating in sports?	Y	N
Does this athlete have any known allergies to any medications?	Y	N
Does this athlete wear glasses or contact lenses? Last eye exam? _____	Y	N
Has this athlete ever blacked out or lost consciousness during physical activity?	Y	N

We consent to the participation of the above-named student in the interscholastic program of St. Michael Parish School including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by the physicians designated by school authorities.

Student: _____ Parent: _____
Date: _____

Health Examination Form

Student's Name: _____
Height: _____ Weight: _____ BP: _____ Pulse: _____

Abnormal Physical Findings:
(including infectious or contagious diseases):

Should there be any limitations placed on this athletes participation in competitive sports?
Yes
No

I certify that on this date I have examined the student and that on the basis of the examination requested by the school, and the student's medical history as furnished to me.
I have found no reason which would make it medically inadvisable for this student to participate in supervised athletic activities.

Physician's Signature: _____
Phone: _____
Date: _____