

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 the supervised activities that are **NOT 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:
