ST. MICHAEL PARISH SCHOOL
Rooted in Faith, Committed to Excellence

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ST. MICHAEL PARISH SCHOOL ATHLETICS
Student Participation Physical Exam Form

**Must be received before student can participate in any sport*

Student Name: _____ Birthdate: _____ Grade: _____
Parents' Names: _____
Address: _____ City/State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Family Doctor: _____ Phone: _____

ATHLETE'S HISTORY

- Has this athlete ever had hospitalization, surgery, injury or serious medical illness? Yes No
  If yes, please explain: _____
- Is this athlete now under the care of a physician or taking medication? Yes No
- Should any limitations be placed on this athlete when participating in sports? Yes No
- Does this athlete have any known allergies to any medications? Yes No
- Does this athlete wear glasses or contact lenses? Last eye exam? _____ Yes No
- Has this athlete ever blacked out or lost consciousness during physical activity? Yes No

We consent to the participation of the above-named student in the inter-scholatic 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.

Parent Signature: _____ Date: _____

HEALTH EXAMINATION FORM

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

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

Should there be any limitation placed on this athlete's 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 by me, I have found no reason which would make it medically inadvisable for this student to participate in supervised athletic activities.

Physician's Signature: _____

Date: _____ Phone: _____