ALL SAINTS CATHOLIC SCHOOL
SPORTS PHYSICAL FORM

Section I / Legal Name of Participant

Last_____ First_____ Middle_____
Address:_____
City:_____ State:_____ Zip_____
Telephone No.:_____
Name of Primary Medical Insurance Company:_____
Policy Number:_____Membership Number:_____
Name on Policy:_____

MEDICAL HISTORY

1.	Are there any injuries requiring medical attention?	Yes	No
2.	Are there any past surgeries or scheduled surgeries?	Yes	No
3.	Is the participant currently under the care of a medical practitioner?	Yes	No
4.	Is the participant currently taking any medication?	Yes	No
5.	Does the participant have any allergies (penicillin, bee stings, etc.)?	Yes	No
6.	Does the participant have asthma/require the use of an inhaler?	Yes	No
7.	Is the participant diabetic/require medication for diabetes?	Yes	No
8.	Does the participant currently require medication?	Yes	No
9.	Does/has the participant have/had seizures?	Yes	No
10.	Does the participant wear glasses or contact lenses?	Yes	No
11.	Does the participant wear a brace or other medical support device?	Yes	No
12.	Does the participant have any other physical limitations or medical conditions?	Yes	No

If you answered Yes to any of the above questions, please provide the question number and an explanation in the following space:

_____
_____
_____

I hereby understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written permission from my child's physician in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signed: _____
Print Name: _____
Relationship to Participant: _____
Dated_____

Section II / MEDICAL PROFESSIONAL USE ONLY

Height	Weight	Eyes
Ears	Mouth	Nose & Throat
Respiratory	Cardiovascular	Neurological
Muskoskeletal	Dermatological	Other

I hereby certify that I am a Licensed Medical Professional and have examined the above named individual and understand that he/she will be participating in a sport/cheer activity program. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in _____
I am therefore clearing this individual for athletic participation without limitation.

Please sign or place medical professional stamp below:

Signed_____Date_____
Print Name_____
Address_____City_____ State_____
Telephone _____