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_________________________
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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:

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