

St. Joseph School Athletic, Medical, and Sports Authorization

THIS IS AN ATHLETIC PHYSICAL ONLY, IT IS **NOT** THE REQUIRED SCHOOL PHYSICAL

This form is to be used by those who plan to participate in **any extracurricular athletic activity** for St. Joseph School. It is **valid for the current school year only.**

TO THE PARENT: Your child wishes to participate in an athletic program sponsored by St. Joseph School. Prior to allowing his/her participation, we require that you secure a physician's examination of your student and complete the following form. Your cooperation is greatly appreciated. This form is **DUE PRIOR TO THE FIRST OFFICIAL PRACTICE. NO PHYSICAL EXAM PRIOR TO MARCH 1 OF THE PREVIOUS SCHOOL YEAR IS VALID.** For students in **FIFTH GRADE**, this form is to be turned in along with the required school physical.

Student Name

Grade

Doctor Name

Phone number

Doctor's Address, City, Zip

TO BE COMPLETED BY THE DOCTOR

Medical restrictions, if any _____

Glasses for sports?

YES

NO

Comments: _____

I hereby certify that I have examined the above-named student, and there appears to be no medical reason why he/she is not physically able to compete in supervised activities sponsored by St. Joseph School.

DOCTOR'S SIGNATURE (please use hand stamp with your Signature)

Date

*ATTENTION PARENTS-PLEASE COMPLETE SECOND PAGE

TO BE COMPLETED BY A PARENT

Pursuant to school regulations, I have obtained a physical examination of my child, and a physician’s certification of this examination is on the first page of this document. Based on that examination, I hereby give my consent for him/her to participate on an athletic team sponsored by St. Joseph School. I understand that St. Joseph School will rely on this consent and physician’s certification as to my child’s physical ability to participate on a team, and I expressly release St. Joseph School, its teachers, and agents from any obligation to make an independent examination or evaluation to determine his/her ability to participate.

I further consent to the administration of emergency treatment upon my child by an attending physician for any illness or injury resulting or occurring in connection with his/her athletic participation.

If and accident occurs, I give my permission for onsite FIRST AID to be administered.
_____Yes _____No

I understand that my child must be covered by parental insurance in order to participate in the sports programs. St. Joseph School does not have separate coverage for school teams.

_____Child covered by parental insurance

Health Insurance Provider_____

Policy Number_____

Please list any allergies, medications, or medical conditions _____

Parent Signature

Date

Parent Signature

Date

EMERGENCY CONTACT INFORMATION:

Home Phone (____) _____

Work Phone : Mother(____) _____

Father(____) _____

Cell Phone: Mother(____) _____

Father(____) _____

Email: Mother _____

Father(____) _____

Relative, friend, or other you authorize St. Joseph School to contact in an emergency situation if unable to contact parents/guardians.

Name_____ Relationship_____ Phone _____

PLEASE BE SURE YOU HAVE COMPLETED ALL OF THE ABOVE