

**Guardian Angels Catholic School 2008 - 2009**

Diocese of St. Petersburg

**PARTICIPATION HEALTH SCREENING**

Required annually in addition to school physical

Student Name \_\_\_\_\_ Grade/HR \_\_\_\_\_

Home Address \_\_\_\_\_

H Phone \_\_\_\_\_ Parent's Work \_\_\_\_\_ Cell \_\_\_\_\_

Student Soc. Sec. Number \_\_\_\_\_ DOB \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Parent's Email Address \_\_\_\_\_

MEDICAL CONCERNS/RESTRICTIONS:

\_\_\_\_\_

CURRENT MEDICATIONS:

\_\_\_\_\_

I understand a sports health screening is necessary for my child's participation in Guardian Angels Catholic School Extra-curricular Sports Program.

I further understand that competitive athletics may result in injury although the school has and will do all it can to reduce the risk of injury. I request a Guardian Angel Catholic School representative to obtain medical treatment for my child in the unlikely event of injury or illness during practice or games and I agree to pay any expenses incurred for such treatment.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

JOINT Custodial PARENT SIGNATURE \_\_\_\_\_

**EXAMINING PHYSICIAN'S CERTIFICATE**

I hereby certify that I have examined \_\_\_\_\_  
on the date indicated below. Based on the past health history s/he has given me and on my physical examination I find this athlete physically able to participate in interscholastic sports.

Any Restrictions? \_\_\_\_\_

PHYSICIANS SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_