

THIS SPORT HEALTH SCREENING FORM NEEDS TO BE FILLED OUT AND SIGNED BY A PHYSICIAN AFTER JULY 1ST FOR THE NEW SCHOOL YEAR. ONCE TURNED IN, IT IS GOOD FOR THE ENTIRE SCHOOL YEAR.

Guardian Angels Catholic School 2010 - 2011

Diocese of St. Petersburg

PARTICIPATION HEALTH SCREENING

Required annually in addition to school physical

Student Name _____ Homeroom: _____

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? _____

PHYSICIAN'S SIGNATURE _____

DATE _____