STUDENT ATHLETIC PHYSICAL FORM

CHILD'S NAME: _____ Grade: _____ DOB: _____

PARENT PERMISSION AND AUTHORIZATION FOR TREATMENT

We hereby give our consent for the above student to represent his/her school in interscholastic athletics at Green Park Lutheran School. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claim, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school. We understand that the school will not provide transportation to any event.

If we cannot be reached in the event of an emergency, we also give consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities.

We further state that we have listed on the back of this form all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment, and we certify that it is correct and complete.

SIGNATURE OF PARENT OR GUARDIAN: _____Date_____

PHYSICAL EXAMINATION

Height _____ Weight _____ B/P _____

VISION HEARING

Normal _____ Glasses / Contacts _____ Normal_____ Abnormal _____

GROWTH DEVELOPMENT

Ears/Nose _____ Heart _____ Musculoskeletal _____ Head/Neck _____

Skin/Glands _____ Mouth/Teeth _____ Genitalia _____

DOES CHILD HAVE MEDICAL OR MENTAL HEALTH DIAGNOSIS? IF YES, PLEASE EXPLAIN: _____

_____

PRESCRIPTION MEDICATIONS? _____

DOES CHILD HAVE ALLERGIES OR ASTHMA? IF YES, PLEASE EXPLAIN: _____

_____

*Inhaler: ____ yes *Nebulizer: ____ yes *Epi-Pen: ____ yes **Yearly Asthma/Allergy Action Plan Required*

ANY OVER THE COUNTER MEDICATIONS? _____

CHILD HAS PERMISSION TO TAKE THE FOLLOWING MEDICATIONS: **Parent signature required yearly on separate Student Medication Form**

Acetaminophen _____(dosage): Ibuprofen _____ (dosage) every 4-6 hours as needed for fever/pain/headache.

LIMITATIONS OR RESTRICTIONS:

Activity restrictions _____ Diet restrictions_____

I certify that I have examined the above student and I could detect no reason for him/her not to participate in supervised athletics for the 2016-2017 SCHOOL YEAR.

Physician's Signature _____ Date _____

Physician's Name (Stamp or Print) _____

Physician's Address _____ Phone _____

A substitute form from your doctor may be submitted, but should contain <u>all</u> of the information listed above.
Please note that Parent Permission & Authorization for Treatment Form above will need to be completed by a parent/guardian and attached to the student physical.