AUBURN AREA CATHOLIC SCHOOL
ATHLETIC HEALTH & MEDICAL INFORMATION

The following is to be filled out by a parent:

Athlete _____ Birth Date: _____

Address _____City_____Zipcode _____

Father _____Phone(Home/Cell)_____(Work)_____

Mother _____Phone(Home/Cell)_____(Work)_____

Emergency Contact: Name_____Phone_____

Family Physician_____Phone_____

List any allergies, medication, contacts/glasses, or special care _____

_____

Health Ins. Co. _____Policy or Group #_____

Phone_____

IN CASE OF SERIOUS ATHLETIC INJURY

In case of serious illness or injury, I hereby request and give my full consent for authorized school personnel to transport my child directly to the nearest hospital, or send by ambulance, if needed, and I will assume all financial obligations. I further authorized any licensed physician or dentist and/or hospital to provide necessary treatment. I understand this permission will continue to be in effect as long as the student is enrolled in Auburn Area Catholic School or playing as a participating member of an Auburn Area Catholic Sports Team.

Parent Signature_____ Date_____

MEDICAL HISTORY

The following is to be filled out by a physician:

Name_____ Age_____ Ht. _____ Wt._____

Nose and Throat_____ Ears_____ Teeth_____

Blood Pressure _____ Heart _____ Lungs_____

Skin Condition _____ Posture _____ Hernia_____

Feet: Athlete's Foot _____ Arches _____ Plantar Wart _____ Other _____

Physician's Recommendations: _____

_____

Physician's recommendations to Auburn Area Catholic School: check the one best suited to the student's health status.

1._____May engage in a regular athletic program.

2._____Should be excused from the athletic program.

Permanently _____ **OR** from _____ to_____

This student may engage in interscholastic athletics ESCEPT THOSE CROSSED OUT.

Basketball Volleyball Cheerleading Soccer

_____ _____

Date of Examination Signature of Physician