

ST. CATHERINE OF ALEXANDRIA

ATHLETIC ASSOCIATION

PHYSICAL EXAMINATION FOR PARTICIPATION IN SPORTS

NAME: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_

ADDRESS: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_

PHONE-HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN: RETURN TO COACH BEFORE FIRST GAME.**

DOES THIS CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE PARTICIPATION IN A COMPETITIVE ATHLETIC PROGRAM? FOOTBALL, BASKETBALL, VOLLEYBALL, CHEERLEADING

ALLERGIES: PLEASE LIST: \_\_\_\_\_  
\_\_\_\_\_

ASTHMA/RESPIRATORY DIFFICULTY? \_\_\_\_\_ SEIZURE DISORDER? \_\_\_\_\_

HERNIA? \_\_\_\_\_

DIABETES? \_\_\_\_\_ HEART DISEASE? \_\_\_\_\_

PLEASE LIST ROUTINE MEDICATIONS AND/OR PHYSICAL LIMITATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ON THE BASIS OF THIS EXAMINATION ON THIS DATE, I APPROVE THIS CHILD'S PARTICIPATION FOR ONE YEAR IN A COMPETITIVE ATHLETIC PROGRAM.

YES \_\_\_\_\_ NO \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

DATE: \_\_\_\_\_