APPLICATION TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS
MEDICAL CERTIFICATE TO BE COMPLETED BY EXAMINING PHYSICIAN

STUDENT'S NAME (LAST, FIRST, MI)	SCHOOL	GRADE

DATE OF BIRTH	HOME PHONE	SPONSOR'S DUTY PHONE

STUDENT'S APPLICATION

I AGREE TO NOTIFY MY SPORTS COACH OF ANY CHANGES IN MY HEALTH STATUS, TO INCLUDE ANY MEDICATIONS I MAY TAKE OR STOP TAKING. THIS APPLICATION TO PARTICIPATE IN ATHLETICS AT THE ABOVE SCHOOL IS MADE WITH THE UNDERSTANDING THAT I HAVE NEVER RECEIVED ANY MONEY FOR PARTICIPATION IN ATHLETIC EVENTS AND THAT I HAVE NEVER COMPETED UNDER AN ASSUMED NAME. AFTER I HAVE REPRESENTED MY SCHOOL IN ANY SPORT, I PROMISE NOT TO COMPETE IN ANY OUTSIDE ATHLETIC CONTEST IN THIS SPORT UNTIL AFTER THE SCHOOL SEASON HAS BEEN COMPLETED.

KEEP IN SCHOOL FILE

DATE:	SIGNATURE OF STUDENT:

PARENT OR GUARDIAN PERMISSION

I HEREBY GIVE MY CONSENT FOR THE ABOVE STUDENT TO HAVE A MEDICAL EXAMINATION (SPORTS PHYSICAL) PERFORMED BY LOCAL U. S. MILITARY HOSPITAL/CLINIC PERSONNEL, TO ENGAGE IN INTERSCHOLASTIC ATHLETICS AT THE ABOVE SCHOOL IN THE APPROVED SPORT(S) CHECKED BELOW, AND TO ACCOMPANY THE TEAM AS A MEMBER ON ITS SCHEDULE TRIPS.

DATE:	PRINTED NAME OF PARENT OR GUARDIAN:	SIGNATURE OF PARENT OR GUARDIAN:

MEDICAL CERTIFICATE TO BE COMPLETED BY EXAMINING PHYSICIAN

	YES	NO
General health is satisfactory?	☐	☐
Is visual correction required for competition? Glasses / Contacts Visual Acuity: right /left Tested with / with out correction	☐	☐
Is there a bridge or false teeth?	☐	☐
Are immunizations current? If no, list immunizations received.	☐	☐
Are there health problems that should be evaluated or treated before participating in competitive sports? Explain:	☐	☐
Is applicant's blood pressure normal? BP / Pulse	☐	☐
Are there medical conditions that may affect participation? (asthma, diabetes) Please advise:	☐	☐
Are there medications that may be required for participation? If so please complete medication form.	☐	☐

☐	Basketball	☐	Golf	☐	Wrestling
☐	Baseball	☐	Gymnastics	☐	Volleyball
☐	Cross Country	☐	Soccer		
☐	Cheerleading	☐	Swimming		Other:
☐	Field Hockey	☐	Tennis	☐	
☐	Football	☐	Track and Field	☐	

I have examined _____ and find him/her to be physically able to compete in the supervised athletic activities checked above. This certificate is valid for one year from date indicated below.

DATE:	PRINTED NAME OF EXAMINING PHYSICIAN:	SIGNATURE OF EXAMINING PHYSICIAN: