

MEDICAL/PHYSICAL INFORMATION

Student's Name		Birthdate		Male <input type="checkbox"/> Female <input type="checkbox"/>
Address				
Phone		Emergency Phone		
Father's Name		Mother's Name		
Pediatrician/Family Dr.		Phone		

SECTION 1				
TO BE COMPLETED BY PARENT/GUARDIAN: (Please check and give dates.)				
Chicken Pox		Lymes Disease		Lymes Medication
Scarlet Fever		Rheumatic Fever		Anemia (Sickle Cell)
Diabetes		Taking Insulin		Insect Sting
Asthma		Using Inhaler		Frequency
Seizure Disorder		Seizure Medication		
Allergies				
Serious injuries/operations				
Physical/emotional handicaps				

SECTION 2									
TO BE COMPLETED BY PHYSICIAN:									
Height		Weight		Bld Pres		Heart		Lungs	
ENT		Hearing		Speech		Teeth			
Vision - Normal:		Right Eye				Left Eye			
Corrected:		Right Eye				Left Eye			
Menstrual History						Painful Menses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Scoliosis									
Last Mantoux administered		Result							
Any evidence of communicable disease									
Any physical/emotional handicaps									
Is student taking any Medication				Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Names and frequency									

SECTION 3									
TO BE COMPLETED BY PHYSICIAN:									
<input type="checkbox"/>	1.	Student is approved for routine school activities							
<input type="checkbox"/>	2.	I found this student abnormal under following headings and make the following recommendations regarding school:							
<input type="checkbox"/>	3.	In order to participate in interscholastic sports the following MUST be completed BEFORE practice begins.							
I find the student is physically qualified to participate in the following sports:									
<input type="checkbox"/>	Field Hockey	<input type="checkbox"/>	Soccer	<input type="checkbox"/>	Basketball	<input type="checkbox"/>	Cheerleading	<input type="checkbox"/>	Softball
<input type="checkbox"/>	Baseball	<input type="checkbox"/>		<input type="checkbox"/>					
Manager Of:									

SECTION 4									
TO BE COMPLETED BY PHYSICIAN:									
Today I have administered the following immunizations:									
Physician's Name (please print)					License #				
Address:									
Physician's Signature					Date				

Continued on Reverse

SECTION 5**TO BE COMPLETED BY PARENT/GUARDIAN:**

The above named student has my permission to participate in the sports activities as indicated above at The Pilgrim Academy, including practices, home and away games. I recognize that it is my responsibility to provide transportation for my child after practices and games. I give my permission for my child to travel with:

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I understand that there are risks/dangers involved with participation in off-campus trips. In consideration of my child being allowed to participate in this event, I agree to assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I agree to hold harmless The Pilgrim Academy, its affiliated organizations, employees, agents, and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation. This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstances are proved in a court of law, I acknowledge and agree that the school can assume no financial liability beyond its actual liability insurance policy in force.

Signature

Date