

PHYSICALS

PHYSICAL EXAM FORMS ARE NORMALLY VAILD FOR TWO SEASONS

IT IS THE OBLIGATION OF THE PARENTS OT ARRANGE FOR A PHYSICAL. YOU MAY GO TO YOUR OWN DOCTOR, OR TO A CLINIC OF YOUR CHOICE.

PHYSICAL EXAM FORMS ARE AVAIABLE FROM OUR PROGRAM DIRECTORS.

REMINDER – NO ONE WILL PRACTICE WITHOT A PHYSICAL ON FILE. EXCEPTIONS WILL NOT BE ALLOWED.

PHYSICAL EXAMINATION

NAME: _____
LAST

GRADE _____ AGE _____ DATE OF BIRTH _____ SEX _____

SCHOOL West Suburban Christian Academy CITY Waukesha

The above named student has been examined and there are no apparent contradictions to participating in interscholastic athletic activities except as follows. (PHYSICIAN NOTE – Please refer to Guide for Athletic Disqualification)

Sports of school activities in which this student cannot participate are (if none – write NONE) _____

If student is restricted or disqualified, please indicate reason(s): _____

Signature of Licensed Physician or Surgeon: _____

Address: _____

City and State: _____

Telephone: _____ Date of Examination _____

Present Home Address _____ Telephone _____

Parents place of Employment: _____

Family Physician: _____ Family Dentist _____

Name of Private Insurance Carrier: _____

Policy numbers and Address: _____

1. I hereby give my permission for the above named student to practice and compete and represent the school in approved interscholastic sports excepting those restricted on this card.
2. I further grant permission for any medical records pertaining to the health of the above named student be made available as necessary to the proper school district personnel.

Signature of Parent of Legal Guardian

DATE _____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION.

HEIGHT _____

WEIGHT _____