SERRA HS ATHLETIC DEPARMENT

STUDENT INFORMATION / PARENT RELEASE / PHYSICAL EXAMINATION RECORD

STUDENT INFORMATION

STUDENT NAME:(LAST, FIRST)	D.O.B:	PARENT / GUARDIAN:
ADDRESS:(INCLUDE CITY, ZIP)	AGE:	HOME PHONE:
	GRADE:	WORK PHONE:
SPORTS:(LIST ALL)		

EMERGENCY CONTACT

NAME : (NON-PARENT / GUARDIAN)	PHONE NUMBERS):

INSURANCE INFORMATION / MEDICAL INFORMATION / RELEASE

INSURANCE:	ALLERGIES:
INSURANCE IDENTIFICATION NUMBER:	PRIMARY PHYSICIAN(NAME, OFFICE PHONE:)
MEDICAL CONDITIONS:	PRIMARY DENTIST (NAME , OFFICE PHONE):

I THE PARENT (GUARDIAN) OF THE ABOVE NAME CHILD, HEREBY, GIVE MY PERMISSION FOR HIS/HER PARTICIPATION IN THE YOUTH ACTIVITIES NAMED ABOVE. I AGREE TO DIRECT MY CHILD TO COOPERATE AND CONFORM WITH THE DIRECTIONS AND INSTRUCTIONS OF THE SCHOOL PERSONNEL RESPONSIBLE FOR YOUTH ACTIVITIES. I AM NOT AWARE OF ANY MEDICAL CONDITION WHICH WOULD PREVENT MY CHILD'S PARTICIPATION IN THE ABOVE LISTED SPORTS TEAMS. I AGREE THAT IN THE EVENT MY CHILD IS INJURED AS A RESULT OF HIS/HER PARTICIPATION IN THE ABOVE LISTED SPORTS INCLUDING TRANSPORTATION TO AND FROM, WHETHER OR NOT CAUSED BY THE SCHOOL OR ITS AGENTS OR EMPLOYEES, RECOURSE FOR THE PAYMENT OF ANY RESULTING HOSPITAL, MEDICAL OR RELATED COSTS AND EXPENSES WILL FIRST BE SOUGHT AGAINST ANY ACCIDENT, HOSPITAL OR MEDICAL INSURANCE OR ANY AVAILABLE BENEFIT PLAN OF MINE OR MY SPOUSE. I HEREBY PERMIT APPROPRIATE NECESSARY MEDICAL TREATMENT TO BE ADMINISTERED TO MY CHILD BY A LICENSED PHYSICIAN AUTHORIZED BY SERRA HIGH SCHOOL PERSONNEL IN CASE OF MY ABSENCE. YOUR SIGNATURE SIGNIFIES YOUR AGREEMENT TO PAY IN A TIMELY MANNER ALL EXTRA FEES RELATED TO THE ABOVE ACTIVITIES THROUGH THE MAIN OFFICE.

PARENT / GUARDIAN SIGNATURE: **DATE:**

PHYSICAL EXAMINATION REPORT (MEDICAL PERSONNEL ONLY)

ANY SIGNIFICANT PAST INJURY OR ILLNESS:

HEIGHT:	WEIGHT:	BLOOD PRESSURE:
EYES:	EARS, NOSE, THROAT:	TEETH:
HEART:	LUNGS:	MUSCLE-SKELETAL:
HERNIA:	REFLEXES:	OTHER:

I CERTIFY THAT I HAVE, ON THIS DATE, EXAMINED THE ABOVE STUDENT AND FIND HIM/HER PHYSICALLY ABLE TO FULLY PARTICIPATE IN THE ABOVE LISTED ATHLETIC PROGRAM ACTIVITIES.

PHYSICIANS SIGNATURE:

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DATE: / /

CONDITION FOUND IN EXAMINATION OR AFTER FURTHER EVALUATION TO THE PHYSICAL ACTIVITY ASSOCIATED WITH ATHLETICS. .

CONDITION: