

MEDICAL HISTORY

Grades 2-5

The following is to be filled out by a physician:

Name _____ Age _____ Ht. _____ Wt. _____

Nose and Throat _____ Ears _____ Teeth _____

Blood Pressure _____ Heart _____ Lungs _____

Skin Condition _____ Posture _____ Hernia _____

Feet: Athlete's Foot _____ Arches _____ Plantar Wart _____ Other _____

Physician's Recommendations: _____

Physician's recommendations to Auburn Area Catholic School: check the one best suited to the student's health status.

1. _____ May engage in a regular athletic program.

2. _____ Should be excused from the athletic program.

Permanently _____ OR from _____ to _____

This student may engage in interscholastic athletics EXCEPT THOSE CROSSED OUT.

Basketball

Volleyball

Cheerleading

Soccer

Date of Examination

Signature of Physician

AUBURN AREA CATHOLIC SCHOOL
ATHLETIC HEALTH & MEDICAL INFORMATION
Grades PS-5

The following is to be filled out by a parent:

Athlete _____ Birth Date: _____

Address _____ City _____ Zipcode _____

Father _____ Phone(Home/Cell) _____ (Work) _____

Mother _____ Phone(Home/Cell) _____ (Work) _____

Emergency Contact: Name _____ Phone _____

Family Physician _____ Phone _____

List any allergies, medication, contacts/glasses, or special care _____

Health Ins. Co. _____ Policy or Group # _____

Phone _____

IN CASE OF SERIOUS ATHLETIC INJURY

In case of serious illness or injury, I hereby request and give my full consent for authorized school personnel to transport my child directly to the nearest hospital, or send by ambulance, if needed, and I will assume all financial obligations. I further authorized any licensed physician or dentist and/or hospital to provide necessary treatment. I understand this permission will continue to be in effect as long as the student is enrolled in Auburn Area Catholic School or playing as a participating member of an Auburn Area Catholic Sports Team.

Parent Signature _____ Date _____



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