

St. Mark Catholic School

1201 Alma Dr. Plano, Texas 75075 (972)578-0610

Sports Medical Clearance

Entering Grade _____ Year _____

This side to be completed by parents

Child's name _____ Sex M F Birthday _____

Address _____

Mother's name _____ Telephone _____

Father's name _____ Telephone _____

In case of emergency in which the parents cannot be reached, please call:

	Name	Relationship	Telephone number(s)
1.	_____	_____	_____
2.	_____	_____	_____

2. _____

Please list the name, relationship and telephone number(s) of those who may pick this child up from school:

****SPECIAL EMERGENCY REFERRAL INSTRUCTIONS****

In the event I cannot be reached or make arrangements for emergency medical attention at the time of illness or injury, I hereby authorize _____ to take my child to:

Name of School

Doctor Address Telephone number

Doctor/Clinic/Hospital Address Telephone number

Parent/Guardian signature: _____

1) Has this child (please explain any yes answers)
a) had any chronic illnesses—i.e. Diabetes, Cystic Fibrosis Yes: _____ No: _____

b) had any allergies that require special attention or medication Yes: _____ No: _____

c) had any past history of head injury, concussion, seizure, etc Yes: _____ No: _____

d) had any heart or blood pressure abnormalities Yes: _____ No: _____

e) need any medication at school Yes: _____ No: _____

2) Are there any special concerns that you have regarding athletic participation for your child? _____

Are there any limitations for your child's participation in physical education or sports? _____

This side to be completed by Physician

Student's name (please print): _____

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present age: yrs. mos.	General appearance			
Height: inches (%)				
Weight lbs. oz. (%)	Skin:			
	Head:			
	Eyes:			
	1) Reflex test			
Other:	2) Cover test			
	Ears			
	Nose, Mouth, Pharynx, Teeth			
	Neck (lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Abnormal findings:

Patient health history, findings, and recommendations:

Physical Activity: Restricted or Unrestricted Explanation:

I have examined the child named on this form, and find that he/she is able to participate in the athletic programs of the school.

Signature

Date

Please print physicians name and address: