ST. ELIZABETH OF THE TRINITY ATHLETICS

ATHLETIC MEDICAL CONSENT FORM

Student Athlete Name: _________________________________Date of Birth: ______________

Grade Level (Circle One): 4th 5th 6th 7th 8th

FOR COMPLETION BY EXAMINING PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT PERFORMING EXAMINATION

Height: ___________ Weight: ____________ BMI: ______________ B/P: _______________

On the basis of the examination on this day, I approve this child's participation in the Interscholastic Athletic Program for St. Elizabeth of the Trinity School for one year.

______ YES ______ NO _____ LIMITED (Please explain)

Known Medical Concerns/Conditions: _____________________________________

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EXAMINING PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT PERFORMING EXAMINATION

Print Name: ____

Signature: ____ Date: __________________

Address:____ Phone: _________________

IMPORTANT-PLEASE NOTE:

This form must be completed, properly signed, returned to the Coach, and approved by the School before any student may officially draw athletic equipment, or officially become a member of any squad at St. Elizabeth School. A completed and signed Illinois Department of Public Health Certificate of Child Health Examination Form may be substituted for this form.