

Medical History
(To be made out by physician)

Name _____ Age _____ Height _____ Weight _____
Vision (R) _____ (L) _____ Correction (R) _____ (L) _____
Nose and Throat _____ Ears _____ Teeth _____
Blood Pressure _____ Heart _____ Lungs _____
Skin Condition _____ Posture _____ Hernia _____

Physician's Recommendations: _____

Physician's Recommendations to the Athletic Participant – Trinity Lutheran School
(check the one best suited to the student's health status)

1. _____ May engage in regular athletic program
2. _____ Should be excused from the athletic program
 - a. _____ Permanently
 - b. _____ From _____ to _____
 - c. This student may engage in interscholastic athletics EXCEPT THOSE
CROSSED OUT.

Basketball Soccer Track Volleyball Softball Cheerleading

(Signature of Physician)

(Date of Examination)

oo

Health and Medical Information
(To be made out by parent)

Athlete _____ Birthdate _____ School: Trinity Lutheran
Address _____

Street _____ City _____ State _____ Zip _____

Father/Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Mother/Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Family Physician _____ Phone _____

List any allergies, medications, contacts/glasses, or special care

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 authorize 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 at Trinity Lutheran School unless revoked in writing.

SIGNATURE OF PARENT/GUARDIAN

DATE