

ATHLETIC MEDICAL AUTHORIZATION
St. Gregory Elementary School

Please Print: (Last Name) (First Name) (Initial)
Grade _____
Birthdate _____

Eyes R _____ L _____ Glasses _____ Hearing R _____ L _____ Height _____ Weight _____

Ear, Nose, Throat _____ Lungs _____

Urinalysis _____ Diabetes _____ Pulse _____

Blood Pressure and Heart _____ Heart Murmur _____

Deformities or present illness _____ Prosthesis _____

Hernia evidence _____ Concussion _____ Epilepsy _____ Other _____

Would athletic competition be injurious? _____

I hereby certify that, on this date, I examined the above student and recommend him/her as being physically able to participate in all supervised athletics and physical education activities, except as noted:

Date Signature of Examining Physician

Health History

- | | |
|---------------------------|-------------------------|
| ____ Allergy to bee sting | ____ Heart murmur |
| ____ Anemia | ____ Hepatitis |
| ____ Arthritis | ____ Hernia |
| ____ Asthma | ____ Hives |
| ____ Concussion | ____ Kidney trouble |
| ____ Diabetes | ____ Migraine headaches |
| ____ Eczema | ____ Pneumonia |
| ____ Emotional problems | ____ Rheumatic fever |
| ____ Epilepsy | ____ Other: |
| ____ Fainting | _____ |

Operations:

(Include year)
Fractures: _____
(Include year)

To which drugs is the student allergic? _____

If student is now under medical treatment list reason and attending doctor:

