

Students

Exhibit - Certificate of Physical Fitness for Participation in Athletics

To be submitted to the Building Principal. (please print)

_____	_____
Student	Sport/Activity
_____	_____
Parent/Guardian	Home phone
_____	_____
Home address	Cell phone
_____	_____
Emergency contact (<i>relationship to student</i>)	Contact phone
_____	_____
Physician	Physician phone

Medical History: Date of Birth: _____ Height: _____ Weight: _____

- | | | | |
|------------------------------------------|-----------------------------------|-------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma: | <input type="checkbox"/> Requires child to self-administer medication |
| <input type="checkbox"/> Epilepsy | | <input type="checkbox"/> Allergies: | <input type="checkbox"/> Requires student to carry EpiPen® |
| <input type="checkbox"/> Other _____ | | | |

List all medications (*prescribed and over the counter*)

Injuries (*brief description and dates*)

Surgeries (*brief description and dates*)

Physical activity restrictions (*brief description and duration*)

I certify that:

1. My child is in good health and is capable of participating in the above sport or activity. No need exists to limit his/her participation. I assume full responsibility for his/her physical condition and participation, and will notify you of any changes.
2. I have completed and submitted the *Authorization for Medical Treatment* form allowing the school to seek medical treatment for my child in the event of a medical emergency when reasonable attempts to contact me are unsuccessful.
3. If my child requires or may need medication while participating in athletics, I have completed and submitted the *School Medication Authorization Form*.

_____	_____
Parent/Guardian signature	Date