

Fayette Academy Sports Medical Form

Must be completed and returned **BEFORE** any sports participation

I. Physician's Certificate

I hereby certify that (name) _____ has been examined by me and found physically fit to engage in all school athletics.

Height _____ Weight _____ Blood Pressure _____
Date: _____ Physician's Signature _____

II. Emergency Treatment

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without a parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

Emergency Information

Name _____ M _____ F _____
Grade _____ Age _____ Date of Birth _____
Parent's Name _____
Home Address _____
Home Phone _____ Father's cell _____ Mother's cell _____
Another Person to Contact _____
Relationship _____ Home phone _____ Cell phone _____
Insurance Company _____ Policy Number _____
Group Name _____ Group Number _____
ALLERGIES _____

III. Parent's Consent

I hereby give my consent for (student's name) _____

TO REPRESENT FAYETTE ACADEMY IN THE FOLLOW SPORTS:

Parent's Signature _____ Date _____