MSHSAA MEDICAL CERTIFICATE – RELEASE

ATHLETE'S PERSONAL INFORMATION

NAME:_____ MALE_____ FEMALE_____

ADDRESS_____ CITY/ZIP_____ AGE____ BIRTHDATE___/___/___

This application to represent my school in interscholastic athletics is entirely voluntary on my part. I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Signed by Student:_____ Date:_____

PARENT PERMISSION AND AUTHORIZATION FOR TREATMENT

I/We hereby give our consent for the named student to represent the school in interscholastic athletics. We will not hold the school responsible in case of accident or injury, whether it be enroute to or from another school or during practice or an interscholastic contest and we hereby agree to hold the school, its employees, agents, representatives, and coaches, harmless from any and all liability, actions, causes of actions, debts, claims or demands of every kind and nature whatsoever which may arise by, or in connection with, participation by my child in any activities related to the interscholastic program of Trinity Catholic High School.

If I/we cannot be contacted and in the event of an emergency, we give consent for the school to obtain through a physician or hospital of its choice such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of school athletic activities.

I/We understand that the school may not provide transportation to all events and that my child/ward may travel as a passenger in a privately owned vehicle which may be driven by a student. Further, I permit/do not permit **(circle one)** my child/ward to drive his/her vehicle to off campus activities.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and I/we certify that it is correct and complete.

The MSHSAA By–Laws state that a student shall not be permitted to practice or compete for a school until it has verification that he/she has athletic insurance coverage. My son/daughter is covered by basic accident insurance for the current school year with:

Name of Insurance Company_____ Policy Number_____

Signature of Parent(s)/Guardian_____ Date_____

PHYSICIAN'S EXAMINATION RECORD

Parent's Name:_____ Home Phone:_____ Work Phone:_____

Doctor's Name:_____ Office Phone:_____

Doctor's Address:_____ City/Zip:_____

Pulse:_____ Rhythm:_____ Blood Pressure:_____ Weight:_____ Height:_____ Heart:_____

Describe any abnormality:_____

Eyes/Ears/Nose/Throat:_____ Describe any abnormality:_____

Abdomen:_____ Describe any abnormality:_____

Hernia: No_____ Yes_____ Genitalia:_____ Reflexes:_____

Extremities and Back: Indicate any history of orthopedic defect(s):_____

Urinalysis:_____ (if indicated) Blood Count:_____ (if indicated) Tetanus within last 5 years:_____

I have on this date examined the above student and from this limited examination, he/she is approved to participate in supervised interscholastic athletic as listed. ***(Physician circle and initial any sport in which student should NOT participate.)***

Baseball Basketball Cheerleading Danceline Football Golf Soccer Softball Swimming Tennis Track Volleyball Wrestling

Physician Signature:_____Date:_____

ADDITIONAL MEDICAL INFORMATION

Parent/Student/Physician – describe below any previous injuries or additional conditions that may affect the athlete's performance or treatment.

_____

_____

_____