



NOTRE DAME HIGH SCHOOL, INC.

Sponsored by the School Sisters of Notre Dame

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SPORTS PHYSICAL/PARENT PERMISSION FORM

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME	GRADE	DATE OF BIRTH	GENDER
PARENT/GUARDIAN NAME			
PARENT/GUARDIAN ADDRESS		HOME PHONE	
PLACE OF EMPLOYMENT		WORK PHONE	

MEDICAL HISTORY

1. ANY HEAD INJURIES? YES NO TYPE AND DATE OF INJURY:
2. ANY FRACTURES? YES NO TYPE AND DATE OF FRACTURE:
3. ANY ALLERGIES? YES NO TYPE:
4. ANY LUNG DISEASE? (I.E. ASTHMA, ETC.) YES NO TYPE:
5. ANY HEART DISEASE? YES NO TYPE:
6. PREVIOUS HOSPITALIZATION? YES NO
FOR WHAT REASON AND DATE OF HOSPITALIZATION:
7. CURRENTLY TAKING ANY MEDICATION(S)? YES NO TYPE AND FOR WHAT REASON:
8. ANY MEDICAL REASON WHY YOUR CHILD SHOULD NOT PARTICIPATE IN ATHLETICS? YES NO WHY?

PARENT/GUARDIAN CONSENT

I hereby give permission for the physician to examine my child so that he/she may obtain health clearance to participate in athletic activities. Therefore, neither the examining physician, nor Notre Dame High School, nor the Guam Public School System is to be held liable for any abnormalities not detected in this examination. Permission is also granted to my child (Name) _____ to participate in the athletic activities approved by the Physician as initialed below for school year: _____.

Parent/Guardian Signature	Date
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THIS PORTION TO BE COMPLETED BY PHYSICIAN

Blood Pressure	Temperature	Pulse	Respiration	Height	Weight	Vision (Right)	Vision (Left)

ATHLETIC CLEARANCE

Basketball	Cross-Country	Football	Volleyball	Track & Field	Softball	Soccer	Tennis
Cheerleading	Non-contact Sport	No Activities	Wrestling (Indicate minimum weight allowed to participate)				
All activities listed above			Further medical examination is needed				

Physician's Signature	Date
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