ECASD Middle Schools—Athletic Permit Card

Examinations are good for TWO YEARS FROM THE DATE of the physical

NAME (Last)_____(First)_____(MI)_____

GRADE_____AGE_____SEX (circle one) M F SCHOOL (circle one) DeLong Northstar South

ADDRESS_____CITY_____STATE_____ZIP_____

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

_____

Sports or school activities in which this student cannot participate are (if none—write NONE)_____

SIGNATURE OF LICENSED PHYSICIAN *_____OR APNP_____

Address_____City_____State_____Zip_____

Telephone_____Date of Examination_____

ALL STUDENTS PARTICIPATING IN INTERSHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIATION

*Physicians may authorize Nurse practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

ECASD Middle Schools—Athletic Permit Card

NAME (Last)_____(First)_____(MI)_____Date of Birth_____

Present Address_____Home Phone_____

Parents' Place of Employment_____

Family Physician_____Family Dentist_____

Name of Your Medical Insurance Carrier_____

Policy Number and Address_____

1. I hereby give my permission for the above named student to practice and compete and represent the school in approved intramural and interscholastic sports except those restricted on this card.
2. I further grant permission for any medical records pertaining to the health of the above named student be made available as necessary to the proper school district personnel and appropriate health care providers including emergency medical personnel.
3. It is recommended that information regarding your child's allergies and prescribed medication be made available.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____