



Catholic Central High School – Department of Phys-Ed

Medical Release Form



Students registered in Physical Education at Catholic Central High School are offered a wide range of varied activities. Sometimes students have medical histories or handicaps, which impair their full and unhindered participation in physical education. Consequently, the students must be provided with adaptive and/or alternative programs. Should your son/daughter have any such difficulty, please describe the problem on the attached document. Please understand that this information is for the protection and benefit of your child. All information is confidential.

Alta. Health Care Number: _____

Name: _____ Grade: _____ Quarter: _____

Address: _____

Name of Mother/Guardian: _____

Business Phone: _____ Home Phone: _____

Name of Father/Guardian: _____

Business Phone: _____ Home Phone: _____

Family Physician: _____ Phone: _____

Clinic: _____ Phone: _____

Family Contact Person: _____ Phone: _____

Please indicate (check box) if your son/daughter has been subject to any of the following:

<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cardiovascular conditions	<input type="checkbox"/> Headaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis or rheumatism	<input type="checkbox"/> Dislocated shoulder
<input type="checkbox"/> Orthopedic problems	<input type="checkbox"/> Chronic nosebleeds	<input type="checkbox"/> Hernia
<input type="checkbox"/> Head or back conditions or injuries (in the past 2 years)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Swollen, hyper-mobile or painful joints
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Knee disorder

Asthma, allergies - If you check this box, please answer the following question.
Does your son or daughter require an epi-pen? Circle: Yes or No

Provide pertinent details of any conditions above: _____

Is your son/daughter a: ___ non swimmer, ___ weak swimmer, ___ confident swimmer

What medication(s) should the participant have on hand during the sport activity? _____

Does your son/daughter wear a medic alert bracelet _____, neck chain, _____, or carry a medic alert card?

If yes, please specify what is written on it: _____

Does your son/daughter wear eyeglasses or contact lenses? If yes, please specify. _____

Other relevant medical condition(s) that will require modification of the program, or specific activities that your child should not participate in (please provide medical reason): _____

If your son or daughter is a special needs student his/her Individualized Program Plan will be followed within the context of the physical education class.

I acknowledge that the information I have provided is correct and give consent to the PE Instructor to use the above information for the purposes described above for Quarter _____ Year _____



Parent Signature: _____

Date: _____

