

International Studies Academy
Department of Athletics
Medical Exam Report

ATHLETE'S NAME

Last First Middle Birthdate Sem/Year

DOCTOR TO COMPLETE

I hereby certify the above named athlete physically fit for competition in sport(s) of:

and may be subject to the following limitations or restrictions:

Known allergies: _____

Signature of Physician State License # Phone Number Date

PARENT TO COMPLETE

1. If the student has health or accident insurance, list company name, policy number and local claims address:

Company Name Policy Number Claims Address

2. _____
Family Doctor's Name Policy Number In an emergency send to: HOSPITAL

3. I hereby give my consent for my son/daughter to compete in the Sport(s) of:

In case of illness or injury, the coach, site administrator or designee is authorized to have the athlete examined & treated. I authorize the medical agency to render treatment.

4. _____
Date Emerg. Phone # Contact Name Parent/Guardian Signature

File with Athletic Director, copy to coach.

COACH'S INJURY/ILLNESS RECORD

Date of In/Illness Type of In/Illness Treatment Report Filed Doctor Seen

