

FRANCIS PARKER SCHOOL

(Please print)

Athletic Physical, Parent Consent, and Insurance

Student's Name _____ / /
 Last First Sex/ Birthdate / Grade

Address		City	Zip
Mother's Name	Home #	Father's Name	Home #
Work #	Car #	Work #	Car #

Emergency Contact _____ Home # _____ Work # _____

Student's Name

 Last

 First

 Sex/ Birthdate/ Grade

PARENTS: PLEASE COMPLETE			PHYSICIAN: PLEASE COMPLETE		
Ins. Co.			Family Dr.		
Policy #			Telephone #		
			Height: Weight: BP:		
			Vision: R20/ L20/		
HEALTH HISTORY	No	Yes = COMMENT	VITALS	-	+ = COMMENT
Chronic illness			Skin		
Surgery (except tonsils)			Head		
Injuries treated by Dr.			Eyes		
Current medications			Ears		
Heat Exhaustion/ stroke			Nose		
Head Injuries			Throat		
Wear glasses or contacts			Dental		
Hearing defects			Lymphatics		
Dental Appliances			Lungs		
Blood pressure			Heart		
Heart problems			Abdomen		
Hernia			Genitalia		
Skin diseases			Neurologic		
Tetanus booster date			Orthopedic		

I give my consent for _____
 to compete in sports and travel with a school rep.
 If injured, this is authorization for medical
 treatment.

Sports Participation: Yes _____ No _____
Limitations:
Further evaluation required:

Parent/ Guardian signature _____	Date _____
Physican signature _____	Date _____

TO REPLY BY FAX, CALL (858) 569-0942