Notre Dame High School, Inc.
Sponsored by the School Sisters of Notre Dame
Accredited by the Western Association of Schools and Colleges
and the Western Catholic Educational Association

SPORTS PHYSICAL AND PARENT/GUARDIAN CONSENT AND HOLD HARMLESS FORM

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME		GRADE		DATE OF BIRTH	
PARENT /GUARDIAN NAME				HOME PHONE	
PARENT/GUARDIAN ADDRESS				CELL 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		REASON AND DATE OF HOSPITALIZATION:	
7. CURRENTLY TAKING 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 AND HOLD HARMLESS

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, the examining physician, Notre Dame High School, Inc., the Guam Public School System, the Department of Defense School System and the IIAAG will not be held liable for any abnormalities not detected in this examination. Permission is also granted to my child named above to participate in inter-scholastic athletics approved by the Physician as initialed below for the school year _____.

I request the school to allow my child to participate in inter-scholastic athletics. I understand that the school will attempt to provide reasonable supervision for my child. However, I understand that injuries can occur; these injuries can, on rare occasions, result in total disability, paralysis, or death.

In consideration for providing the opportunity for my child to play inter-scholastic athletics, I hereby release and save harmless Notre Dame High School, Inc., its employees, and volunteers from any liability for any injury that my child may sustain while participation as a member of the team.

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Parent/Guardian Signature **Date**

THIS PORTION TO BE COMPLETED BY PHYSICIAN

Blood Pressure	Temperature	Pulse	Respiration	Height	Weight	Vision (right)	Vision (left)

ATHLETIC CLEARANCE

Baseball	Basketball	Cheerleading	Cross Country	Football	Paddling	Rugby	Soccer	Softball
Tennis	Track & Field	Volleyball	Wrestling (indicate minimum weight allowed to participate)			Non-contact sport		
No athletic activities			**All athletic activities listed above**		Further medical examination is needed			

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Physician Signature **Date**