OUR LADY OF MOUNT CARMEL SCHOOL
AND
CATHOLIC YOUTH ATHLETIC ASSOCIATION

ATHLETIC MEDICAL AUTHORIZATION

____
Please Print: (Last Name) (First Name) (Middle Initial)

Grade___________________________
Birthdate________________________

Eyes R______ L______ Glasses______ Hearing R______ L______ Height________ Weight________________

Ear, Nose, Throat________________________________ Lungs____

Urinalysis_____________________ Diabetes_________________ Pulse_________________________________

Blood Pressure and Heart__________________________ Heart Murmur_________________________________

Deformities or present illness_________________________ Prosthesis___________________________________

Hernia evidence___________ Concussion____________ Epilepsy__________ Other_____________________

Would athletic competition be injurious?____

I hereby certify that, on this date, I examined the above student and recommend him/her as being physically able to participate in all supervised athletics and physical education activities, except as noted:

_______________ ____
Date Signature of Examining Physician

Health History

_____allergy to bee sting
_____anemia
_____arthritis
_____asthma
_____concussion
_____diabetes
_____eczema
_____emotional problems
_____epilepsy
_____fainting
_____heart murmur
_____hepatitis
_____hernia
_____hives
_____kidney trouble
_____migraine headaches
_____pneumonia
_____rheumatic fever
_____other

operations:____
(Include year)

fractures:____
(Include year)

To which drugs is the student allergic?____

If student is now under medical treatment list reason and attending doctor:________________________________

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