

ST. MICHAEL CATHOLIC SCHOOL – ATHLETIC FORM #3
PHYSICIAN'S AND PARENTS' CERTIFICATE FOR ATHLETICS
(BOYS AND GIRLS)

Student's Name: _____ Date of Birth: _____
Last First Middle Mo. Day Year

Address: _____

PHYSICIAN'S REPORT

Height _____ Weight _____ Body Type (Maturation status) _____
Eye, Ear, Nose, Throat _____ Hearing _____
Heart _____ Blood Pressure _____ Lungs _____
Joint Function: Shoulders _____ Elbows _____ Hips _____ Knees _____ Wrists _____
Ankles _____ Feet _____ Hands _____
Dental: Cavities, Bridges, False Teeth (Circle defects) Other _____
Skin (Fungus? Staph?) _____ Neuromuscular _____
Genital-Urinary _____ Hernia _____

Circle positive points and explain. Previous history of: Allergy – Head Injury – Unconsciousness – Tetanus
Immunization – Bone or Joint Disease and/or Injury – Heart Disease – Hypertension – Renal Disease and/or
Injury – Diabetes – Emotional Disturbance – Epilepsy. Explanation: _____

Is student taking any medication routinely? Yes _____ No _____ If yes, explain: _____

I certify that on this date, I have examined the above student as indicated by the items checked, and
recommend him/her as being physically able to participate on the supervised athletic teams CIRCLED
BELOW:

VOLLEYBALL FOOTBALL SOCCER BASKETBALL SOFTBALL TRACK AND FIELD

DATE

SIGNATURE OF EXAMINING PHYSICIAN

Please have your doctor return this form to: St. Michael Catholic School Phone: (713) 621-6847
Attn: Athletic Director FAX: (713) 877-8812
1833 Sage Road
Houston, TX 77056