



ST. ANASTASIA ATHLETICS
ATHLETIC MEDICAL CONSENT FORM

Student Athlete Name: _____ Date of Birth: _____

Grade Level (Circle One): 5th 6th 7th 8th

**FOR COMPLETION BY EXAMINING PHYSICIAN/ADVANCED PRACTICE
NURSE/PHYSICIAN ASSISTANT PERFORMING EXAMINATION**

Height: _____ Weight: _____ BMI: _____ B/P: _____

On the basis of the examination on this day, I approve this child's participation in the Interscholastic Athletic Program for St. Anastasia School for one year.

_____ YES _____ NO _____ LIMITED (Please explain)

Known Medical Concerns/Conditions: _____

EXAMINING PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT PERFORMING EXAMINATION

Print Name: _____

Signature: _____ Date: _____

Address: _____ Phone: _____

IMPORTANT-PLEASE NOTE:

This form must be completed, properly signed, returned to the Coach, and approved by the School before any student may officially draw athletic equipment, or officially become a member of any squad at St. Anastasia School. A completed and signed Illinois Department of Public Health Certificate of Child Health Examination Form may be substituted for this form.