

# OUR LADY OF LOURDES ATHLETIC PROGRAM ATHLETIC PERMIT/PARENT PERMISSION/MEDICAL INFORMATION

9/09

STUDENT'S NAME \_\_\_\_\_  
Last First M.I. SCHOOL YEAR

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
5 6 7 8  
YEAR IN SCHOOL

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

PARENT(S) NAME(S) \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

FATHER'S/GUARDIAN'S PLACE OF EMPLOYMENT \_\_\_\_\_ WORK PHONE \_\_\_\_\_ / \_\_\_\_\_ CELL PHONE \_\_\_\_\_

MOTHER'S/GUARDIAN'S PLACE OF EMPLOYMENT \_\_\_\_\_ WORK PHONE \_\_\_\_\_ / \_\_\_\_\_ CELL PHONE \_\_\_\_\_

\*\*\*\*\* EMERGENCY CONTACT (Name and relationship) \*\*\*\*\*  
\*\*\*\*\* PHONE \*\*\*\*\*

FAMILY PHYSICIAN: \_\_\_\_\_  
 HOSPITAL PREFERENCE: Aurora \_\_\_\_\_ Bellin \_\_\_\_\_ St. Mary's \_\_\_\_\_ St. Vincent \_\_\_\_\_

Prior to a student practicing for or competing in athletics (including travel to/from the activity), the student must have permission from his/her parent/guardian **AND** be covered by medical insurance. If your family does not have a medical insurance plan, a limited individual policy may be obtained through the school. Parents/guardians are responsible to notify school administration and the Athletic Director if insurance is cancelled or terminated.

INSURANCE CARRIER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

Medical Conditions (include allergies): \_\_\_\_\_

Prescription Medications Currently Taking: \_\_\_\_\_

Comments: \_\_\_\_\_

**\*\* Participation in athletics has inherent risks which may cause serious injury, or in rare cases, fatal injuries. \*\***

**\*\*\*\* I hereby give my permission for the above named student to practice, compete and represent the school in the OUR LADY OF LOURDES ATHLETIC PROGRAM. I understand that practice sessions and competitions for sports are sometimes held off campus; I give permission for my athlete to walk or ride to these practices as necessary. IN CASE OF MEDICAL EMERGENCY, I understand that every effort will be made to contact the parent/guardian and/or emergency contact listed above. If neither can be reached, I hereby give permission to the coach/advisor to seek proper medical treatment for the athlete. \*\*\*\***

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN DATE

**A medical examination every two years is *highly recommended* by the Diocesan Board of Education Regulation and the Our Lady of Lourdes School Committee.**

**(Please complete one of the sections below)**

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows: Sports or school activities in which this student cannot participate in are (if none, write NONE): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

SIGNATURE OF LICENSED PHYSICIAN \_\_\_\_\_ DATE OF EXAMINATION \_\_\_\_\_

ADDRESS (street, city, state, zip) \_\_\_\_\_ PHONE \_\_\_\_\_

**I DO NOT FEEL MY CHILD NEEDS A PHYSICAL AT THIS TIME \_\_\_\_\_ (CHECK HERE)**

\_\_\_\_\_  
 SIGNATURE OF PARENT/GUARDIAN DATE