PEACE LUTHERAN SCHOOL
3161 LAWNDALE RD
SAGINAW, MI 48603

ATHLETIC PHYSICAL AND MEDICAL INFORMATION
2024-25 SCHOOL YEAR

(A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR)

STUDENT INFORMATION
(to be completed by parent/guardian – PLEASE PRINT)

STUDENT'S NAME:	LAST	FIRST	M.I.	SEX	GRADE	DATE OF BIRTH
STUDENT'S ADDRESS:	NUMBER AND STREET	CITY	STATE	ZIP CODE		
FATHER'S NAME:		PHONE NUMBER	E-MAIL ADDRESS			
MOTHER'S NAME:		PHONE NUMBER	E-MAIL ADDRESS			
FAMILY DOCTOR:	PHONE NUMBER	STUDENT'S HOME PHONE:				

MEDICAL TREATMENT CONSENT & LIABILITY STATEMENT

I hereby give permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness, etc. until such time as I may be contacted. I hereby give my approval for my son/daughter to participate in any and all of Peace Lutheran School athletic activities. I assume all risks and hazards incidental to such participation, and hereby waive, release, absolve, and agree to hold harmless Peace Lutheran School, the School Policy Committee, the athletic director, faculty, staff, volunteer coaches, referees, volunteers, league officials, organizers, and participants from any claim arising out of any injury except to the extent covered by accident or liability insurance.

PARENT'S INSURANCE COMPANY:	CONTRACT #
PARENT'S SIGNATURE:	DATE:

EMERGENCY INFORMATION

STUDENT'S NAME:				GRADE
EMERGENCY CONTACT #1:	NAME	RELATIONSHIP	CELL PHONE	HOME PHONE
EMERGENCY CONTACT #2:	NAME	RELATIONSHIP	CELL PHONE	HOME PHONE
FAMILY DOCTOR:	NAME		PHONE NUMBER	
KNOWN ALLERGIES:				
DRUG REACTIONS:				
CURRENT MEDICATIONS:				

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STUDENT'S MEDICAL HISTORY

(to be completed by parent/guardian – PLEASE PRINT)

LAST	FIRST	M.I.	SEX	GRADE	DATE OF BIRTH
STUDENT'S NAME:					

PLEASE CHECK ALL BELOW THAT APPLY

MEDICAL CONDITION	HAS HAD	HAS	MEDICAL CONDITION	HAS HAD	HAS	FAMILY HISTORY	YES	NO
fainting			blurred vision			heart disease		
diphtheria			headaches			hypertension		
scarlet fever			fainting			fainting		
rupture			convulsions			cancer		
rheumatic Fever			seizures			diabetes		
poliomyelitis			painful joints			stroke		
pneumonia			backaches			bronchitis		
asthma			pounding of heart			pneumonia		
diabetes			shortness of breath			seizures		
heart disease			frequent urination			bleeding disorders		
kidney disease			cough			muscle disease		
tuberculosis			nosebleeds			kidney disease		
jaundice			frequent sore throats			blindness		
stomach pains			allergies			skin disorder		

PHYSICAL EXAMINATION & MEDICAL CLEARANCE

(to be completed by doctor, physician's assistant, or nurse practitioner doctor)

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

PLEASE CHECK THE APPROPRIATE COLUMN

SYSTEM	NORMAL	ABNORMAL
vision		
ears		
nose		
throat		
teeth		
orthopedic		
thyroid		
chest		
lungs		
heart		
abdomen		

I certify that I have examined the student and recommend him/her as being able to compete in supervised athletic activities ***NOT*** crossed out below.

BASKETBALL CHEER/POM PON PHYSICAL EDUCATION TRACK

SOCCER VOLLEYBALL SOFTBALL WRESTLING

Signature of Examining Physician: _____ **Date:** _____