

Griffin School District #324  
Athletic Clearance/Permission to Participate

Name \_\_\_\_\_ Sex: F M Birthdate \_\_\_\_\_

Circle the sports student may participate in:

Soccer Volleyball Archery Basketball Wrestling Track

**THIS SECTION IS TO BE COMPLETED BY A LICENSED PHYSICIAN**

1. Has the student been diagnosed with any of the following: \_\_\_ Hernia \_\_\_ Diabetes  
\_\_\_ Heart Disease \_\_\_ Rheumatic Fever \_\_\_ Epilepsy \_\_\_ Kidney Disease

2. Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

3. Vision or Hearing problems \_\_\_\_\_

4. Any surgeries, serious illnesses or fractures:

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

The above student has been found to be physically fit to compete in interscholastic sports with no limitations: \_\_\_\_\_ (Physicians initials)

The above student may participate in interscholastic sports WITH limitations as follows:

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

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date of Exam

Physician Name and Phone Number (printed or office Stamp)

Note to physician: please keep a copy of this completed form in patient's file. If need arises, a copy can be faxed to Griffin Middle School at 866-9684.

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**THIS SECTION TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN**

1. In the event of an emergency, and emergency contacts cannot be reach, do you authorize and direct the school authorities to call Medic 1? **YES NO**

2. Do you Authorize Medic 1 or other emergency service personnel to administer treatment and transport your child to the most feasible medical center if necessary? **YES NO**

3. If an ambulance is called, do you agree to be financially responsible for this expense? **YES NO** (If NO, please explain what steps you would like school personnel to take to ensure the well-being of your child.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Skyward Student Management provides emergency contact information for coaching staff. Please make changes through Skyward Family Access as necessary.

Griffin Middle School  
Athletic Clearance and Emergency Card

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Lives with: (circle one) Both parents    Mother Only    Father Only    Other

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Emergency Contact #1 \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

In the event of an emergency and none of the above persons are reached, do you authorize and direct the school authorities to call Medic 1? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you authorize Medic 1 or other emergency service personnel to administer treatment and transport your child to the most feasible medical center if necessary? \_\_\_ Yes \_\_\_ No

If an ambulance is called, do you agree to be financially responsible for this expense?  
\_\_\_ Yes \_\_\_ No (If not please explain what steps you would like school personnel to take to ensure the well-being of your child.) \_\_\_\_\_

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

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**PLEASE RETURN THIS FORM TO THE MIDDLE SCHOOL – COACHES WILL RECEIVE A COPY AT THE BEGINING OF EACH SPORT.**