

**Students**

**Exhibit - Certificate of Physical Fitness for Participation in Athletics**

*To be submitted to the Building Principal. (please print)*

Student	Sport/Activity
Parent/Guardian	Home phone
Home address	Cell phone
Emergency contact ( <i>relationship to student</i> )	Contact phone
Physician	Physician phone

**Medical History:**      Date of Birth: \_\_

Height: \_\_\_\_\_      Weight: \_\_\_\_\_

Heart condition       Diabetes       Asthma:       Requires child to self-administer medication  
 Epilepsy       Allergies:       Requires student to carry EpiPen®  
 Other \_\_\_\_\_

List all medications (*prescribed and over the counter*)

Injuries (*brief description and dates*)

Surgeries (*brief description and dates*)

Physical activity restrictions (*brief description and duration*)

**I certify that:**

1. My child is in good health and is capable of participating in the above sport or activity. No need exists to limit my child’s participation. I assume full responsibility for my child’s physical condition and participation, and will notify you of any changes.
2. I have completed and submitted the *Authorization for Medical Treatment* form allowing the school to seek medical treatment for my child in the event of a medical emergency when reasonable attempts to contact me are unsuccessful.
3. If my child requires or may need medication while participating in athletics, I have completed and submitted the *School Medication Authorization Form*.

Parent/Guardian signature	Date
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Adopted: 8/10/2004

Revised: 7/17/2018, 07/25/2023