

St. Joseph School Parental Request and Physicians Order for Sports

(For students who wish to participate in the athletic program)

This form is to be completed to implement care and prevention of injuries during practices and games both home and away.

To the best of my knowledge as the parent or guardian of _____
I agree that my child is physically fit and able to participate in the athletic program at St. Joseph School.

With each team there will be a medical kit that contains many items. Please put a check next to the items we can use on your child in case of an emergency:

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> bandages | <input type="checkbox"/> gauze | <input type="checkbox"/> cold pack |
| <input type="checkbox"/> ice | <input type="checkbox"/> burn spray | <input type="checkbox"/> pre-wrap |
| <input type="checkbox"/> athletic tape | <input type="checkbox"/> ace bandage | <input type="checkbox"/> Neosporin |
| <input type="checkbox"/> sterile eye wash | <input type="checkbox"/> sunscreen | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> advil | <input type="checkbox"/> alcohol prep pads | |
| <input type="checkbox"/> hydrogen peroxide | | |

I, as the parent or legal guardian of _____, hereby request and authorize St. Joseph School and its nurse and/or designated employees to help in the care and prevention of athletic injuries.

In case of emergency please contact:

Name _____ Phone _____ Relation _____
Name _____ Phone _____ Relation _____

For the coaches knowledge my son/daughter is on this medication:

My son/daughter is allergic to: _____

Parent/Guardian Signature _____ Home Phone _____ Work Phone _____ Date _____
To be completed by Physician:

It is safe for the above student to receive the treatment marked in the above list. The student, _____, is to the best of my knowledge able to participate in the athletic program at St. Joseph School.

Dr. Name _____ Dr. Signature _____
Practice _____ Phone _____