Print Form

Sacramento Country Day School Athletic Clearance 20__-20__

2636 Latham Drive, Sacramento, CA 95864, Fax: 916-481-6016

I am aware that my son/daughter ____________________ will be involved in playing and practicing in sports that may involve risks of injury. I understand that the dangers and risks from playing or practicing any sport include, but are not limited to: death, serious neck or spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of the muscular-skeletal system, serious injury to virtually all internal organs, and serious injury or impairment to other aspects of the body, general good health and well-being. I hereby give my consent for the above-named student to participate in school athletic activities *except:*

____

and to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school, its employees, agents, representatives, coaches, and volunteers responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel.

Comments: ____

Signature of Parent or Guardian ____

Address (if different from below) ____

Phone ______________________ Date ______________

PHYSICIAN'S CERTIFICATION - ATHLETIC CLEARANCE

Good from July 1 - June 30 each school year.

To be completed and signed by the examining physician.

PLEASE PRINT

Name of Student ______________________ Date of Examination ___________

Address ____

Grade ______ Age ______ Height ______ Weight ______ Blood Pressure ______

Past Illness or Injury ____

Eyes ______ Ears ______ Hearing ______ Respiratory ______ Cardio ______

Liver ______ Spleen ______ Hernia ______ Musculoskeletal ______ Pulse ______

Genitalia ______ Labs: Urinalysis ____________ Other ____________

Comments ____

I certify that I have, on this date, examined the above named student and find him/her physically able to compete in supervised athletic activities, ***except*** those listed below:

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Date __________ Examining Physician's Signature ______________________________

Physician's Address ______________________________ Phone #: ______________

Please return completed form to the SCDS Athletic Department or fax to 916-481-6016.