AMERICAN ACADEMY
EDUCATE | INNOVATE | EXPLORE

Physician Permission for Athletic Participation

TO BE COMPLETED BY PARENT/GUARDIAN

Student name: _____ Grade: _____

Date of birth: _____ Sex (circle): Male / Female

Street address: _____ City: _____ Zip: _____

Emergency Contact Information

Parent/guardian name: _____ Phone: _____

Email: _____ Alternate phone: _____

Additional contact name: _____ Phone: _____

Email: _____ Alternate phone: _____

Student's healthcare provider name: _____ Phone: _____

Student's dental care provider name: _____ Phone: _____

Preferred hospital: _____ Phone: _____

Insurance carrier: _____ Policy/group number: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER	
I hereby certify that I have examined the above-named student and that this student was found physically fit to engage in American Academy's school athletics program (which includes but is not necessarily limited to cross country, volleyball, basketball, and soccer).	
Date of physical (valid for 365 days unless rescinded)	
Provider signature (must be signed by an MD, DO, NP, PAC or DC)	
Provider name (printed)	
Provider address	
Provider phone	