MORTON GROVE SCHOOL DISTRICT 70

6200 LAKE STREET • MORTON GROVE, IL 60053-2499 • (847) 965-6200 • Fax (847) 965-6234

PARK VIEW SCHOOL ATHLETIC MEDICAL & SPORTS AUTHORIZATION FORM

THIS IS AN ATHLETIC PHYSICAL ONLY. IT IS NOT THE REQUIRED SCHOOL PHYSICAL.

To the Parent: Your son/daughter may desire to participate in interscholastic athletics at Park View School. Prior to allowing him/her to **try out**, the school district requires that you secure a physician's examination of your son/daughter and complete this form. Your cooperation is greatly appreciated.

TO BE COMPLETED BY THE STUDENT

Name__________________________________ Grade 6 7 8 (Circle One)

Parent's Name__________________________ Phone Number__________________________

Home Address__________________________ Town__________________________________

Name of Doctor_________________________ Phone Number__________________________

Doctor's Address________________________ Town__________________________________

I agree to abide by all the rules set forth by the School District and the Coaching Staff while representing my School District and community.

Student's Signature____________________________

TO BE COMPLETED BY THE DOCTOR

Name of Student____

Medication____

Comments:

Athletics Allowed: All Sports______ Soccer________ Volleyball_______
(please check) Track_________ Basketball_____ Cheerleading_____

I hereby certify that I have examined the above named student and there appears to be no medical reason why he/she is not physically able to compete in supervised athletic activities checked above at Park View School.

Doctor's Signature___________________________________ Date:__________________
Please use hand stamp with your signature

-OVER-

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TO BE COMPLETED BY THE PARENT

Pursuant to school regulations, I have obtained a physical examination for my son/daughter, and a Physicians Certificate of this examination is on the reverse side. Based on that examination, I hereby give my consent for him/her to participate in interscholastic athletics. I understand that the School District will rely on this consent and accompanying certificate as to my son's/daughter's physical ability to participate in these sports, and I expressly release the School District, its teachers and agents from any obligation to make an independent examination or evaluation to determine his/her ability to participate.

I further consent to the administration of emergency treatment upon my son/daughter by an attending physician for any illness or injury resulting or occurring in connection with his/her athletic participation.

I understand that my son/daughter must be covered by one of the below Insurance Programs in order to compete in the Interscholastic Sports Program.

(Please check below)

Parental Insurance covered_____________
School Time covered_____________
24 Hour covered_____________

Parent's Signature_________________________________ Date____________________

BE SURE YOU HAVE COMPLETED ALL OF THE ABOVE.

TURN THIS FORM IN AT YOUR EARLIEST CONVENIENCE—

DO NOT WAIT TO THE LAST MINUTE.