Physician Clearance, Personal Data, Permission to Treat for Dixon High School

Date of Physical: _____

Name of Athlete: _____

Student I.D. #_____

Date of Birth: _____**Grade in School:** 9 10 11 12

Name of Parent(s)/Guardian(s): _____

Home Address: _____

Parent/Guardian Contact Information:

_____/_____/_____/_____

Home phone Work phone Cell phone e-mail Address

In Case of Emergency:

Name: _____Relationship:_____

_____

Home phone Work phone Cell phone

Physician Clearance:
I hereby certify that the above names student was examined by me and found to be physically fit to engage in all sports, except those listed below:

_____

_____ _____

Physicians Signature Date

Permission to Treat/Consent Form: I hereby give my consent for the above named student to:

a. Be examined by a physician;
b. Participate in all sports as a competitor for the Dixon Unified School District with the understanding that participation in sports may lead to permanent injury or death;
c. Travel with a representative of the school when participating in athletics;
d. Be treated by a doctor in case of illness or injury while under the supervision of the Dixon Unified School District.

Parent/Guardian Signature: _____ Date: _____

Insurance Carrier: _____

Parents: Please list any chronic illnesses {i.e. Asthma, etc…) or major injuries your student/athlete has experienced:

_____

Allergy Alert: Please list all allergies to-Food, Pollen, Medicines or Stinging insects: _____