

PMA SPORTS PARTICIPATION MEDICAL FORM



Student's name: _____

Grade / Teacher: _____

1. Has your child had a routine health exam over the last year?

Yes _____ No _____ If yes, date _____

(Please file a copy of the physical form with the school nurse)

2. Are there any past or present injuries, chronic conditions, or illnesses which could influence your child's participation in this PMA sports program?

Yes _____ No _____ If yes, please specify _____

3. Does your child have any allergies that we need to be aware of?

Yes _____ No _____ If yes, please specify _____

4. Is your child currently taking any medications? No _____ Yes _____

Name of medications _____

5. Is your child covered by medical insurance? Yes _____ No _____

Insurance Company: _____

Policy # : _____

Phone # to be called to pre-authorize treatment: _____

Physician's Name: _____

Physician's Phone Number: _____

I confirm that my child is physically able to participate in PMA's sports programs.

Signature _____

Date _____