

SCHOOL DISTRICT OF PHILADELPHIA INTERSCHOLASTIC ATHLETIC PARTICIPATION

Rules for the Management and Control of Interscholastic Athletics – Article IV – Eligibility of Players and Coaches Section A-1. A student shall not represent his/her school in an interschool practice or contest unless she/he has the written consent of his/her parents and the certification of his/her physical fitness by a physician. In accordance with School District policy, Form PEH-19, Certification, Competitive Games, must be on file in the school for each team player.

STUDENT INFORMATION

SCHOOL SECURITY NO.	GRADE	STUDENT I.D. NO.	STUDENT SOCIAL
LAST NAME	FIRST	M.I.	BIRTHDATE <input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS	CITY	STATE	ZIP CODE PHONE NO.
PARENT OR GUARDIAN NAME			
ADDRESS IF DIFFERENT		PHONE NO. IF DIFFERENT	
EMERGENCY CONTACT		PHONE NO.	RELATIONSHIP

PARENT CONSENT

I hereby give my consent to the student named above to practice for and participate in all competitive games and contests with the exceptions listed below. In addition, I give my permission for travel to and from these programs and to emergency treatment as deemed necessary by the medical personnel designated by the program authorities.

Exceptions: _____

This permission is granted for the _____ – _____ school year.

Signature of Parent or Guardian _____ Date _____

PHYSICIAN CERTIFICATION

I have examined the student listed on reverse of this card and find the individual physically qualified to practice for and participate in all competitive games and contests for the _____ - _____ school year, with the following exceptions: _____

Special Instructions or Limitations (i.e. diet, medications, precautions, allergies): _____

Has student had or now have (circle): allergy, asthma, bone fracture or dislocation, congenital abnormality, contacts or glasses, diabetes, epilepsy, head injury, hearing loss, heart trouble or murmur. If yes, specify details.

Has student ever had any serious illness, injury or operation? (circle): Yes No If yes, specify details.

Does student take medication regularly? (Circle): Yes No Explain: _____

Date of last tetanus booster _____ Height _____ Weight _____

Physician's Signature _____ Date _____

(please print or stamp):

Physician's name _____

Address _____

Phone No. _____