2018-2019 ARCHBISHOP RIORDAN HIGH SCHOOL MEDICAL EXAMINATION AND RELEASE FORM

It is the policy of Archbishop Riordan High School that this form must be completed and returned to the school prior to a student's participation in any interscholastic activity, including team practices. Please complete both sides of this form, **retain a copy for your records** and return to the **Archbishop Riordan Athletics Office.**

Student's Name: _____ DOB: / / **Grade:** 9 10 11 12

Address: _____ City/State: _____ Zip: _____

Known Allergies to Medication: Yes/No If yes, please indicate: _____

Insurance Name: _____ Plan ID#: _____

Parent 1 Name: _____ Parent 2 Name: _____

Parent 1 Primary Contact#: _____ Parent 2 Primary Contact#: _____

Emergency Contact Person: _____

Relationship to Student: _____Contact #: _____

HEALTH HISTORY
Please indicate below any current or previous health issues of the student

_____

_____

_____

EXAM TO BE COMPLETED BY PHYSICIAN (Licensed MD or DO) Date of Exam: / /
It is state law and a school requirement that all students must have a complete physical examination by a physician each year in order to participate in interscholastic athletics, including practices.

The above student has (*please circle one*): PASSED EXAM/PASSED CONDITIONALLY/FAILED - Please list any medical concerns, medications or significant findings that would prohibit this individual from competing in interscholastic athletics:

_____

_____

Physician Signature: _____ Print Name: _____

Address: _____ Phone: _____

-OVER-***PARENTS / GUARDIANS MUST COMPLETE ADDITIONAL INFORMATION ON THE BACK SIDE OF THIS FORM.

Student's Name: _____ DOB: / / Class Year: _____

AUTHORIZATION FOR CONSENT TO TREATMENT I/We the undersigned parents/guardians of _____ do by authorize the Riordan Staff/Coaches/Faculty Members as agents for the undersigned to consent to any necessary medical treatment and/or hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician licensed under the provisions of the Medical Practice Act or any specially licensed or trained health care professional.

Date: / / Signed: _____ (Parent/Guardian)

TRANSPORTATION WAIVER I/We hereby give my/our consent for the above student to represent his school in interscholastic athletics. I/We also give him permission to travel in school approved transportation on trips and will not hold the school responsible in case of accident or injury, whether it is en route to or from a school practice or an event. I/We hereby agree to hold the school, the Archdiocese of San Francisco and all its employees harmless from any and all liability which may arise in connection with the activities related to interscholastic athletics.

Date: / / Signed: _____ (Parent/Guardian)

FOOTBALL INSURANCE WAIVER If your son is involved in the FOOTBALL program he must be covered by insurance before he is allowed to practice. The Archbishop Riordan High School student policy does not cover the sport of football. Therefore he must be covered by either your family plan or you may choose a special plan offered by the school. *Please check the appropriate item below.*

_____ My son is not a participant in the football program.
_____ I/WE the undersigned parent/s/guardian/s certify that the above student is insured against injury by the following insurance:

Plan: _____ Company/Plan# _____ I/We will take out the special insurance policy offered at Archbishop Riordan High School: YES / NO

Date: / / Signed: _____ (Parent/Guardian)

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