Renaissance Academy

Student Medical Record / Sports Form

A yearly physical examination is required of each student prior to the start of school.

Child's Full Name:_____ DOB:_____ M F

In order to satisfy required statistical information for grant approval, please indicate ethnicity.

African/American_____ Multi-Racial_____ Caucasion_____ Hispanic/Latino_____ Other_____

RELEASE AND WAIVER OF RESPONSIBILITY I, hereby, (for myself, my heirs, executors and administrators) waive and release any and all rights and claims for all loss and/or damages I may have against Renaissance Academy, CYO, the Diocese of Gary, the school, city or town in which an event is contested, their representatives, successors and assigns, for any and all injuries suffered by me in said event. I also give my permission for the free use of my child's name and/or picture in any broadcast, telecast, or other account of sports and CYO events. I give permission for my child's school to send a copy of my child's physical to the CYO Office if requested.

_____

Parent/Guardian Printed Nane/s Signature Date

Physician's Name:_____ Phone:_____

Address: _____

Street City State Zip Code

To be completed by the child's physician

Height: _____ Weight: _____ BP:_____/_____ Pulse: _____ Date of last Tetanus Shot: _____

Any Allergies (penicillin, bee stings, etc.) ? _____

	Normal	Findings
Heart		
Lungs:		
Skin		
Hernia		
Urine		

Immunization Record

Please attach a complete immunization record with dates. The Indiana State Department of Health requires a minimum of: DTaP/DTP/DT/Td, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella.

History of Diseases		
Measles:	Mumps:	Chickenpox:
Whooping Cough	German Measles	:

Physician's Report

Please report on the overall health and development of this child including any concerns, needed medications, or important information.

_____

_____

I hereby certify that I have examined the above individual and find him/her to be in good health for admission to your school, and participation in all school and sports activities, except:_____ (If none, please state 'NONE')

Physician's Signature:_____ Date of Exam: _____

(Must have current date to be valid)

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