

**Beth Tfiloh Community School
Athletic Permit / Medical Release Form**

(Please return this form to the Athletic Department)

Participants name: _____ Grade: _____ Date of Birth: _____

Address: _____

Home Phone: _____ School: _____

In an emergency notify: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

Date of last exam: _____

Any limitations or known allergies? _____

We give our consent for Beth Tfiloh staff to use their own judgement in securing medical aid and ambulance service in case the parents cannot be reached: _____yes _____no

Please check a space: _____ Student is covered by schools insurance

_____ Blue Cross/ Blue Shield (policy #) _____

_____ Other commercial insurance (policy # and company) _____

It is understood that time after school will be required for practice and competition. The school will provide proper and reasonable supervision at practices and games. Beyond this point of proper supervision, the school cannot assume responsibility for injuries. Additionally, a student is financially responsible for replacement cost of athletic equipment and uniforms which are not returned within ten days after the close of a given season.

I have read and completed the above form and I hereby give my son/daughter permission to participate.

Date: _____ Signed: _____

ATHLETIC DEPARTMENT

(Please return this form to the Athletic Department)

PHYSICAL EXAMINATION FORM

I hereby certify that I have examined

FIRST

MIDDLE

LAST

GRADE: _____

and have found that he/she is medically capable of participating in a full range of Interscholastic Sports with **NO LIMITATIONS.**

Name of Physician: _____

Telephone Number: _____

Date of Examination: _____

Physician's Signature: _____

COMMENTS: _____
