DISTRICT #225 INTERSCHOLASTIC ATHLETIC PHYSICAL FORM

PER IHSA GUIDELINES, THIS PHYSICAL IS VALID FOR 13 MONTHS FROM THE ACTUAL PHYSICAL DATE

TO BE COMPLETED BY THE PARENT AND STUDENT:

STUDENT NAME: _____ Male or Female SCHOOL ID #: _____

NAME OF SPORT (S): _____

Year in School: 9 10 11 12 Date of Birth _____ School Attended Last Year: _____

Parent(s) Name: _____ Home Phone: _____

Home Address: _____ City: _____

Name of Doctor:_____ Doctor's Phone: _____

Doctor's Address: _____ City: _____

DISTRICT #225 PARENT CONSENT FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

I (we) as parent/legal guardian understand that the school district has made available an accident insurance program in which my child may enroll and that the program is optional and limited to coverage specified in the brochure. I (we) realize there is a possibility that child may suffer injury, including permanent paralysis or death, as a result of participation in such interscholastic competition or preparation therefore. I (we) further understand that the school district disclaims any financial responsibility for the costs of medical treatment, hospitals, ambulances or paramedics, etc. arising out of or by virtue of an injury to my (our) child while participating in such interscholastic competition or preparation therefore. My (our) child has my (our) approval to participate in interscholastic sports.

IHSA BANNED SUBSTANCE TESTING POLICY – CONSENT to RANDOM TESTING

Any student-athlete who ingests or otherwise uses any of the banned substances (complete list can be found in either our student handbook or athletic handbook) without written permission by a licensed physician, to treat a medical condition, violates IHSA bylaw 2.170 and is subject to IHSA penalties, including ineligibility from competition. The IHSA will test certain randomly selected individuals and teams that participate in state series competitions for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school. No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

TO BE COMPLETED BY DOCTOR/PHYSICIAN:

STUDENT NAME: _____ HEIGHT: _____WEIGHT: _____

COMMENTS: _____

Athletics Allowed: **ALL SPORTS** _____

Badminton _____	Cross Country _____	Poms _____	Track & Field_____
Baseball _____	Football _____	Soccer _____	Volleyball _____
Basketball _____	Golf _____	Softball _____	Water Polo _____
Cheerleading _____	Gymnastics _____	Swim/Dive_____	Wrestling _____
*GBN only, Bowling _____	Lacrosse _____	Tennis _____	*GBS only, Girls *Field Hockey _____

I hereby certify that I have examined the above named student and there appears to be no medical reason why he/she is not physically able to compete in supervised athletic activities, indicated above, in District #225.

Doctor's Signature: _____ **Actual Physical Date:** _____

(please use hand stamp with signature)