



BISHOP BAUMGARTNER MEMORIAL CATHOLIC SCHOOL

281 Calle Angel Flores, Sinajana, Guam 96910

671-472-6670/671-477-2677/671-477-1026/671-477-4010/671-477-4003/671-477-4028(fax)

MEDICAL CLEARANCE

THIS PORTION TO BE COMPLETED BY PARENT(S) OR LEGAL GUARDIAN(S):

Name of Student:	Date of Birth:	Grade:
Home Address:	Home Phone:	
Father's Name:	Mother's Name:	
Father's Employer:	Mother's Employer:	
Father's Work Number:	Mother's Work Number:	

MEDICAL HISTORY: (please check No or Yes appropriately)

1.	Head Injuries?	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	When?
2.	Fractures?	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	When?
3.	Allergies?	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	Type?
4.	Lung Disease? (Asthma, etc.)	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	Type?
5.	Heart Disease?	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	Type?
6.	Previous Hospitalization?	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	Why?
7.	Currently taking any medication(s)?	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	For what reason?
8.	Any medical reason why this child should not participate in Athletics?					

PARENTAL CONSENT:

I, hereby give my permission to examine my child so that he/she may obtain health clearance for: () **Initial admission to BBMCS**; () **Participation in ATHLETIC Activities**; () **Participation in Interscholastic Sports Activities**. Therefore, neither the examining physician nor Bishop Baumgartner Memorial Catholic School is to be held liable for any abnormalities not detected in this examination.

Permission is also granted to my child, _____ to participate in the **ATHLETIC ACTIVITIES** approved by the doctor as signed for school year: _____.

Parent/Guardian Signature: _____

Date: _____

THIS PORTION IS TO BE COMPLETED BY PHYSICIAN:

Blood Pressure:	Temperature:	Pulse:	Respiration:
Height:	Weight:	Vision/Right:	Vision/Left:
Hearing/Right:	Hearing/Left:	TB SKIN TEST: (Needed for Initial Admission to attend BBMCS)	Results/Date Read:

I have examined the above named child and find HIM/HER physically able to attend Bishop Baumgartner Memorial Catholic School and/or participate in the following activities initialed below for School Year _____.

ALL ACTIVITIES LISTED BELOW: _____

BASKETBALL _____

RUGBY _____

VOLLEYBALL _____

SOCCER _____

CROSS COUNTRY _____

Non-Contact Sport: _____

No Activities: _____

Further medical examination indicated: _____

NAME OF PHYSICIAN (PRINT)

SIGNATURE AND AUTHORIZED STAMP

DATE