



Academy of Our Lady of Guam

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"...dedicated to excellence."

ATHLETIC CLEARANCE

PARENTAL CONSENT:

I give permission for Physician to examine my daughter _____, so that she may obtain Health clearance to participate in Athletic activities. Therefore, neither the examining physician nor the Academy of Our Lady of Guam is to be held liable for any abnormalities not detected in this examination.

Permission is also granted for my daughter to participate in athletic activities approved by the Physician for School Year 2023-2024

Parent Signature _____ Date: _____

Name of Student _____ Date of Birth _____ Grade _____

Parents: Father _____ Mother: _____

Legal Guardian(s) _____ Phone _____

Father's Place of Employment _____ Phone _____

Mother's Place of Employment _____ Phone _____

Legal Guardian(s) Place of Employment _____ Phone _____

Home Address _____

MEDICAL HISTORY

- | | | | |
|-----------------------------------|----------|-----------|--------------------|
| 1. Any Head Injuries: | _____ No | _____ Yes | If yes, when _____ |
| 2. Any Fractures: | _____ No | _____ Yes | If yes, when _____ |
| 3. Any Allergies: | _____ No | _____ Yes | If yes, when _____ |
| 4. Any Lung Disease | _____ No | _____ Yes | If yes, when _____ |
| 5. Any Heart Disease | _____ No | _____ Yes | If yes, when _____ |
| 6. Previous Hospitalization? | _____ No | _____ Yes | If yes, when _____ |
| 7. Currently Taking Medication(s) | _____ No | _____ Yes | |
| Name of Medicine (s) _____ | | | |

THIS PORTION TO BE COMPLETED BY PHYSICIAN:

Blood Pressure: _____ Temperature: _____ Pulse: _____ Respiration: _____

Height: _____ Weight: _____ Vision: _____ Hearing: _____

I have examined the above named student and find her physically able to participate in interscholastic athletic activities.

Name of Physician _____ Signature _____ Date _____

Clinic _____ Phone _____

Address _____

(Clinic stamp to be placed above)

THIS PORTION TO BE COMPLETED BY LABORATORY:

DRUG TESTING RESULTS: **POSITIVE** _____ **NEGATIVE** _____

COCAINE

METHAMPHETAMINE

THC

Any comments _____

Name of Physician/Technician _____ Signature _____ Date _____

Clinic _____ Phone _____

Address _____

(Clinic stamp to be placed above)