

- KEY**
 O No Defect
 ✓ Slight Defect
 X Marked Defect

Illinois Elementary School Assn.

PHYSICIAN'S CERTIFICATE FOR ATHLETES

If student transfers,
 this card should be
 sent to new school.

Name _____ School _____ Birth Date _____

REQUIRED:	20__	20__	20__	20__	RECOMMENDED	20__	20__	20__	20__
MONTH-DAY					URINE: Spec. Grav.				
HEIGHT					Albumen				
WEIGHT					Sugar				
GEN. POSTURE					Casts				
HEART: Murmur					TONSILS				
Rhythm					NOSE AND THROAT				
Blood Pressure					GLANDS				
RATE: Normal					EARS: Right				
After 15 Hops					Left				
After 2 Min.					TEETH				
HERNIA					EYES: Right				
LUNGS: Percussion					Left				
Auscultation					BLOOD TESTS:				
ORTHOPEDIC: Feet					TUBERCULIN TEST:				
Spine					OTHER DEFECTS:				
CONTAGION:									

IN THE SPACE BELOW, INDICATE ATHLETIC ACTIVITIES IN WHICH STUDENT SHOULD NOT PARTICIPATE:

- 20 _____
- 20 _____
- 20 _____
- 20 _____

EXAM BY:

- 1st : _____ M.D.
- 2nd : _____ M.D.
- 3rd : _____ M.D.
- 4th : _____ M.D.

PARENTS' PERMISSION BLANK

Our son or daughter (named on reverse side of this card) has our permission to take part in:

**Cross-Country, Baseball, Softball, Wrestling, Basketball,
Volleyball, Track and Field Sports**
(cross out those not approved)

under the direction of the school during the year of

20 ____ - 20 ____

20 ____ - 20 ____

20 ____ - 20 ____

20 ____ - 20 ____

The school will take reasonable care and precaution to prevent accidents, but the school, or teachers, are not responsible if any accident should occur in practice or games.

I am in full accord with this agreement.

1st year — Date _____
Parent's Signature _____

2nd year — Date _____
Parent's Signature _____

3rd year — Date _____
Parent's Signature _____

4th year — Date _____
Parent's Signature _____

*Physical examination must be done annually.
Each exam is good for a one-year period.*