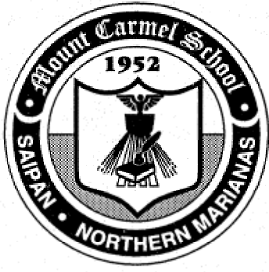


Mount Carmel School

Post Office Box 500006
Saipan, MP 96950
Tel: (670) 234-6184/234-7188
Fax No. (670) 235-4751
Email: mtcarmel@pticom.com
Web: http://www.mtcarmel-edu.net

Medical Clearance for Athletic Activities*

This letter acknowledges that ____
(Name of student)
has been seen by a medical professional who has determined that the above named

student is medically fit for participating in the athletic activity

____ at Mount Carmel School.

____
Name and Title of Medical Professional

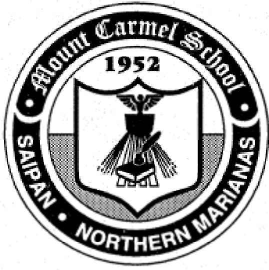
____
Name of Medical Establishment

____
Signature of Medical Professional Date

____
Signature of Parent/Guardian Date

Please provide notes or comments that would be helpful for athletic director (i.e. the student is on medication or has asthma, diabetes, et cetera):

* The Medical Establishment may use their own form for sports activities. If so, please attach.



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Mount Carmel School
Athletic Medical Release

Player: ______________________________ Date of Birth: _____________________

Parent/Guardian Legal Authorization:

In case of an emergency, if family the physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, Emergency Room Physician).

Family Physician: ______________________________ Phone: ________________

Address: ____

In case of an emergency contact:

____
Name Phone Relationship to Athlete

____
Name Phone Relationship to Athlete

Please list any allergies/medical problems, including those requiring maintenance medication (i.e. Diabetic, Asthma, Seizure Disorder).*

Medical Diagnosis Medication Dosage and Frequency

____
____
____
____

Last date of Tetanus Toxoid Booster: ____

____
Parent/Guardian signature

* The purpose of this listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.