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 2024-2025

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)*