OFFICE OF SCHOOL NURSE
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2023 SUMMER CAMP AND ACTIVITIES MEDICAL CERTIFICATION
St. Thomas/St. John Interscholastic Athletic Association and Physician Consent

PHYSICIAN CONSENT

This is to certify that I am a licensed physician and that I have examined _____ age _____.
I consider the above student physically able to participate in organized, competitive athletic activities for the school year **2022-2023** in any sport NOT CROSSED OUT below.

Swimming	Tennis	Flag Football	Tackle Football
Volleyball	Sailing	Track & Field	Basketball
Weight Lifting	Softball	Cross-country	Soccer
Baseball	Yoga	Wrestling	Gymnastics
Martial Arts	Dance	Push Fitness Camp	other _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address Telephone

PARENT CONSENT REQUIRED

This is to certify that I am the Parent/Guardian of _____
who was born on _____ and is enrolled in Antilles School. As Parent/Guardian, I give express permission for the above-named student to participate in organized, competitive athletic activities from **2022-2023** and in any and all sports activities in which the student is medically certified and able to participate. The student may travel with any school team of which the student is a member. Furthermore, I authorize the school to obtain any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or travel.

I acknowledge that such activities have an inherent risk of injury, regardless of the sport, and that on rare occasions, injuries may be severe and, in extreme cases, may even result in death.

I have read and understand the above statements.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/ Guardian Print Telephone