

# Athletic Physical Authorization Form

\_\_\_\_ I will use my primary care physician for my son's/daughter's athletic physical

\_\_\_\_ I authorize the School Physician to assume the role as health care provider and perform my son's/daughter's athletic physical in the office of the high school nurse.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

**\*\*This form MUST be signed prior to receiving an athletic physical. Bring this form along with a signed Permission Slip, Emergency Contact Form, Health History Questionnaire.**