

# MaST COMMUNITY CHARTER SCHOOL

## AFTER SCHOOL FITNESS CENTER PARTICIPATION

A student shall not be allowed to use the Fitness Center after school unless he/she has the written consent of his/her parent/guardian and the certification of his/her physical fitness by a physician. In accordance with school policy, said certification must be on file in the school for each participating student. NOTE: A PIAA sports physical will be considered acceptable certification if it was submitted during the current school year.

### STUDENT INFORMATION

Last Name First Name M.I. Pupil I.D. No.

Street Address City State Zip Code

Phone Number Birth Date Grade Homeroom No. Sex

Parent or Guardian Name

Address if Different Phone No. if Different

Emergency Contact Phone No. Relationship

### PARENT OR GUARDIAN CONSENT

I hereby give my consent to the pupil named above to utilize all fitness center equipment with the exceptions listed below. In addition, I give my permission for emergency treatment as deemed necessary by the medical personnel designated by the program authorities.

Exceptions: \_\_\_\_\_

This permission is granted for the \_\_\_\_\_ school year.

Signature of Parent or Guardian: \_\_\_\_\_

Date \_\_\_\_\_

(over)

## PHYSICIAN CERTIFICATION

I have examined the student listed on this form and find the individual physically qualified to utilize the fitness center equipment that includes cardiovascular and weight training machines for the \_\_\_\_\_ -- \_\_\_\_\_ school year, with the following exceptions:

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Special Instructions or Limitations (i.e. diet, medications, precautions, allergies):

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Has pupil had or now have (circle): allergy, asthma, bone fracture or dislocation, congenital abnormality, contacts or glasses, diabetes, epilepsy, head injury, hearing loss, heart trouble or murmur. If yes, specify details.

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Has pupil ever had any serious illness, injury or operation? (circle):            Yes            No

If yes, specify details.

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Does pupil take medication regularly? (circle):            Yes            No

Explain: \_\_\_\_\_

Date of last tetanus booster \_\_\_\_\_            Height \_\_\_\_\_

Weight \_\_\_\_\_            Blood Pressure \_\_\_\_\_

Physician's Signature \_\_\_\_\_            Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Stamp required in this area: