PERMISSION SLIP

Please complete this section for our records of attendance –

Student Name (please print)

Street Address

City State Zip Code

Day Phone Number of Parent or Guardian Evening Phone

Full Name of School

County / District Where School is Located

________________________________has my permission to participate in the
(Student Name – Print)

Clearance Physical Examination Program by Providence Hospital on **August 26, 2017**.

I understand that this program is a screening program. If any medical condition is found that would need further evaluation, the providers of the program will make a referral. Clearance to participate in a sports program will not be granted until further evaluation is complete.

Printed Name of Parent / Guardian Date

Signature of Parent / Guardian Date