MONTOURSVILLE AREA SCHOOL DISTRICT

NURSE’S OFFICE

School Physical Permission Form

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for my child to receive a physical examination by Dr. Beall (school physician) at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child’s School

During school hours on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date of Examination

The purpose of the physical is for:

\_\_\_\_ In compliance with the School Health Law on mandated physical examinations for students in grades K or 1, 6 and 11.

\_\_\_\_ In compliance with PIAA rules for participation in school sports.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature