FAMILY MEDICAL CENTER
Rocky Mount

804 English Road Suite 100
Rocky Mount, N.C. 27804

Parental Consent for Sports Physical Examination

Date:_____

I am the parent/legal guardian of:_____.
(student's name)

School Name:_____

1. I consent to the provision of a sports physical examination to my child by a physician of Rocky Mount Family Medical Center, P.A. for the purpose of determining whether there are any evident medical conditions that would put the Student at a greater risk of injury when participating in interscholastic sports.
2. The information provided in the Student's written history is accurate and up-to-date.
3. I understand this examination is limited to an examination for evident medical conditions that could affect interscholastic sports participation. I further understand that this examination is not intended to be a full medical physical.
4. I understand abnormal findings and failed physical exams should be followed up by my student's personal care provider (PCP).
5. I release Rocky Mount Medical Center, P.A., its physicians, and its employees and agents from any and all liability arising from the provision of this physical examination.
6. I understand the above policy and have given correct information.

Parent/Legal Guardian Signature:_____

Witness Signature:_____