



**ST AGNES ATHLETIC ASSOCIATION  
PHYSICIAN'S CERTIFICATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Middle Initial First

Place of Birth (County & State) \_\_\_\_\_ Grade \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

The above named student has been examined and there are no apparent contraindications to participating in any sport of his/her choice at St. Agnes School except as follows:

Sports or school activities in which this student cannot participate are (if none – write none)

\_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY & STATE \_\_\_\_\_  
TELEPHONE \_\_\_\_\_

**This certification is valid for 2 years from the date indicated above.**

**Please return the attached Physical form if needed /Permission Form to:  
St. Agnes Parish  
ATTN: Athletic Director  
12801 W. Fairmount Ave  
Butler, WI 53007**