exer URGENT CARE™

SPORTS PHYSICAL REGISTRATION

Student Name: _____ _____

Gender: M F Date of Birth: _____ / _____ / _____

Parent Name: _____ _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Email Address: _____

Relationship to Student: _____ Sport: _____

Signature of Patient or Guardian: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT AUTHORIZES RELEASE OF SPORT PHYSICAL FORMS FROM OUR FACILITY TO:

Name of Provider/Facility: _____

Provider/Facility Address: _____

City: _____ State: _____ Zip Code: _____

Parent / Guardian Printed Name: _____

Signature of Patient or Guardian: _____ Date: _____