



## PERMISSION SLIP

Please complete this section for our records of attendance –

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Student Name (please print)

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Street Address

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City

State

Zip Code

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Day Phone Number of Parent or Guardian

Evening Phone

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**Full Name of School**

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County / District Where School is Located

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\_\_\_\_\_ has my permission to participate in the  
(Student Name – Print)

Clearance Physical Examination Program at Providence Hospital on **July 26, 2008**.

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.

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Printed Name of Parent / Guardian

Date

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Signature of Parent / Guardian

Date