

# OGLETHORPE CHARTER SCHOOL



## PRE-PARTICIPATION PHYSICAL PACKET CHECKLIST

Students must have a physical examination dated after June 1<sup>st</sup> for the current school year. Physical packets from the previous school year are not valid for the current school year.

Student Name: \_\_\_\_\_ Grade for this school year: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**All forms must be completed and turned in. You must use this paperwork:**

\_\_\_\_\_ Physical Packet Checklist

\_\_\_\_\_ Clearance Form (physician's signature required)

\_\_\_\_\_ Physical Examination Form (physician's signature required)

\_\_\_\_\_ Special Needs Form (as needed, physician's signature required)

\_\_\_\_\_ History Form (parent's/guardian's and student's signatures required)

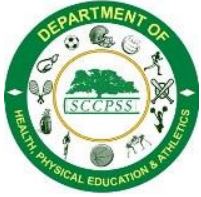
\_\_\_\_\_ Permission/Med Release Form (parent's/guardian's & student's signatures required)

\_\_\_\_\_ Emergency Contact Form (parent's/guardian's signature required)

\_\_\_\_\_ GHSA Heat & Humidity form (parent's/guardian's & student's signatures required)

\_\_\_\_\_ Concussion Awareness (parent's/guardian's & student's signatures required)

**Make sure the student's name appears on every page!**



Make sure the student's name appears on every page!  
**EMERGENCY CONTACT & INSURANCE INFORMATION**

Student's Name (Legal) \_\_\_\_\_

Social Security # \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_  
D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ 2018-2019 Grade Level: \_\_\_\_\_

Address: \_\_\_\_\_, GA \_\_\_\_\_  
STREET CITY ZIP

Student's Home Phone #: \_\_\_\_\_ Student's Cell Phone #: \_\_\_\_\_

Child Lives With: \_\_\_\_ Father \_\_\_\_ Mother \_\_\_\_ Both \_\_\_\_ Other: \_\_\_\_\_

Father/Guardian's Name: \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Father/Guardian's Employer: \_\_\_\_\_

Father/Guardian's Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ ext \_\_\_\_

Mother/Guardian's Name: \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mother's Employer: \_\_\_\_\_

Mother/Guardian's Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ ext \_\_\_\_

Parent/Guardian contact e-mail address: \_\_\_\_\_

Emergency Contact & Relationship (must be 21 or older): \_\_\_\_\_

Contact Home Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Contact Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Primary Physician: \_\_\_\_\_ Office Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ ext \_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Co: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ ext \_\_\_\_

**\*\*PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD\*\***

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications & Condition: \_\_\_\_\_

**PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT ABSENCE**

\*I give permission for representatives of Savannah Chatham County Public School System to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation and treatment by certified athletic trainers at away competitions.

Print Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_



## PERMISSION & MEDICAL RECORD RELEASE FORM

Student's Name: \_\_\_\_\_

Last

First

M.I.

### ASSUMPTION OF RISK AND PERMISSION TO TREAT

I am aware playing or practicing to play/participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play/participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social, and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play/participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold the Savannah Chatham County Public School System, its direct and contracted employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Savannah Chatham County Public School System activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and/or sickness occur to the participant listed above, and the participant is under the supervision of Savannah Chatham County Public School, and the participant's parent / legal guardian is unavailable to give his/her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to a licensed health care professional or agency to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold treating health care professional/agency and/or the Savannah Chatham County Public School System financially responsible for any medical care given. An insurance policy may be available through the school for an additional cost.

I specifically acknowledge that **Football** and **Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports: Basketball, Baseball, Cheerleading, Lacrosse, Soccer, Softball, and Volleyball** which involve greater risk of injury than **non-contact sports: Bowling, Cross Country, Equestrian, Golf, Rowing, Swimming, Track & Field and Tennis**.

\_\_\_\_\_  
Student's Signature                      Date\_\_\_\_\_  
Parent /Guardian Signature                      Date

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

#### General Disclosure:

I hereby authorize the treating health care professional/agency to release information from my medical records for the purpose of payment, treatment or operations to their Business Associate Partner (which includes; the Attending School's Coaching Staff and Administrators) and any Hospital in case of an Emergency Situation. This authorization shall be valid for the duration of the 2018-2019 school year. It is subject to revocation by the patient, or the parent/guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once the treating health care professional/agency discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

\_\_\_\_\_  
Student's Signature                      Date\_\_\_\_\_  
Parent/Guardian Signature                      Date

## **GHSA: HEAT & HUMIDITY POLICY**

### **Heat and Humidity Awareness:**

GHSA has a statewide practice policy for extremely high heat and humidity that list guidelines for monitoring the heat during sports that occur in the warmer months. This includes practices, games, and voluntary conditioning.

#### **GUIDELINES FOR HYDRATION AND REST BREAKS:**

- Rest time should involve both unlimited hydration intake (water or electrolyte drinks) and rest without any activity.
- For football, helmets should be removed during rest time.
- The site of rest should be a “cooling zone” and not in direct sunlight.
- When the WBGT reading is over 86:
  - Ice towels and spray bottles filled with ice water should be available at the “cooling zone” to aid the cooling process
  - Cold immersion tubs must be available for practices for the benefit of any player showing early signs of heat illness.

Please refer to BY-LAW 2.67-GHSA Practice Policy for Heat and Humidity for more details:

<http://www.ghsa.net/sites/default/files/documents/sports-medicine/HeatPolicy2013.pdf>

It is recommended that all guidelines be followed in such a way that the best interests of our students be made our number one priority. It is also recommended that coaches constantly teach our students about proper hydration throughout each day. It is important that student-athletes be allowed to carry water with them during the day and hydrate themselves, on days of practices and games, while the weather has the possibility of reaching critical levels in relation to the heat and humidity.

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
***Student Athlete Signature***

\_\_\_\_\_  
***Date***

\_\_\_\_\_  
***Parent/Guardian Signature***

\_\_\_\_\_  
***Date***

## Memorial Sports Medicine

### CONCUSSION AWARENESS INFORMATION AND GUIDELINES

The purpose for this document is to provide crucial information for student-athletes and parents/legal guardians. This form must be signed by both the athlete and parent/legal guardian prior to tryouts, workouts or other forms of participation.

#### Concussion Awareness Information:

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor “ding” to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short term or long-term). A concussion is a brain injury that results in temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

#### COMMON SIGNS OF A CONCUSSION:

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Foggiess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

Please refer to BY-LAW 2.68-GHSA Concussion policy for more details:

[http://www.ghsa.net/sites/default/files/documents/sports-medicine/2013GHSAConcussion\\_Form.pdf](http://www.ghsa.net/sites/default/files/documents/sports-medicine/2013GHSAConcussion_Form.pdf)

#### Student-Athlete Concussion/Head Injury Guidelines:

I affirm that:

- It is my responsibility as a student athlete or as the parent/legal guardian of a student athlete to report all injuries and illnesses to my Athletic Trainer or a licensed medical professional/agency.
- I have fully disclosed, in writing, all prior head injury related events and medical conditions and will disclose any future conditions to my Athletic Trainer or treating healthcare professional/agency.
- I understand the importance of and will immediately report any and all signs and symptoms of a head injury, including concussion, to a licensed medical professional/agency and my Head Coach.
- I understand there is the possibility that participation in any sport may result in a head injury and/or concussion.
- I will be provided with the Heads Up-Concussion Fact Sheet / NCAA Concussion Fact sheet for student-athletes.
- If there are questions or I wish to discuss any areas and issues that are not clear to me concerning head injuries, I have the contact information of a licensed medical professional/agency.
- I acknowledge that no piece of equipment can prevent injury/illness/concussion. Specifically, helmets or soccer headbands may help to prevent catastrophic head injury but do not significantly reduce the risk of a head injury, including concussion. I understand that it is my responsibility to wear (or to ensure the student-athlete wears) any equipment issued to me (or the student-athlete) in the appropriate manner.
- I agree to read and abide by all warning labels on any equipment before use.
- I have read and reviewed the following statement released by the National Operating Committee on Standards for Athletic Equipment (NOCSAE)
  - **Helmet Warning Statement** *(For those student-athletes who will play football at any level):*
    - **“Keep your head up. Do not use this helmet to butt, ram, or spear an opposing player with any part of this helmet or faceguard. This is in violation of football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent. No helmet can prevent all head or neck injuries a player might receive while participating in football.”**

**BY SIGNING I AFFIRM THAT I HAVE READ THIS FORM AND I UNDERSTAND ALL THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
Student Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

<b>Medicines and Allergies:</b> Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking	
_____	
_____	
_____	
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please identify specific allergy below.	
<input type="checkbox"/> Medicines	<input type="checkbox"/> Pollens <input type="checkbox"/> Food <input type="checkbox"/> Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease                          Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain “yes” answers here

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\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	<b>Yes</b>	<b>No</b>
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

**Explain "yes" answers here**

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**Please indicate if you have ever had any of the following.**

	<b>Yes</b>	<b>No</b>
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

**Explain "yes" answers here**

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**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

### PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/ ( / )	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO



# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_  
\_\_\_\_\_

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

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Other information \_\_\_\_\_

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