Dear Parents/ Guardians:

We at Health Services look forward to serving you and your children during school year. Please bring the following items to Health Services during orientation. This will help ensure that all the student's needs are taken care of for the upcoming school term.

- ☐ Immunization record (if any updates have occurred) (Ga form 3231)
- ☐ Insurance form and copy of insurance card (front and back) *****
- ☐ **Medical Authorization Form** signed by the parent and physician.* **(**Medication cannot be given if the form is not signed by both the parent and the physician**.)**
- ☐ 2 week supply of prescription medication (in original container with label)
- ☐ **Health Services Record** *
- ☐ **Emergency Health Care Plan** signed by physician*
- ☐ **Physical form** signed by physician (Required ONLY for students participating in sports)
- ☐ **Eating and Feeding Evaluation** form signed by physician (Required ONLY if your child requires a special diet or alternative meal plan.

***If not received on the first day, please note that we <u>WILL NOT</u> be able to treat the student and it may become a health risk to have student remain in school without the proper documentation.**

Thank you in advance for your cooperation in this matter. If you have any questions, please feel free to call us at the clinic at (478) 751-6083, ext 8110. If you are unable to reach us at the clinic, please call the school office at (478) 751-6083, ext. 1270.

Sincerely,

Health Services

STUDENT'S NAME _____ TODAY'S DATE _____

MEDICAL AUTHORIZATION FORM

Permission is granted to the Nurses at the Georgia Academy for the Blind and their designee to supervise my child in taking the following prescribed medication. As the parents/guardian of the above named student at the Georgia Academy for the Blind, I do hereby authorize GAB to act as my representative in giving consent for acute/emergency medical, dental, ophthalmology and/or optometry treatment as well as any psychiatric/psychological counseling necessary, during the school year. In case of an emergency, prior to any major medical treatment, every effort will be made to contact me. As parent/guardian, I will assume responsibility for all expenses involved in the treatment of my child not covered by the school or other insurance. I assume responsibility for expenses incurred related to purchasing prescription medication for my child. GAB will not be financially responsible for providing prescription medication to students. I will provide a valid insurance card to GAB to be used for my student to obtain acute/emergency medical services and/or medication.

I authorize the release of any health care information from any health care facility or physician to the school physician or the school nurse. I authorize the release of any and all health care information from the school physician or the school nurse, which in their best judgment is necessary for the health and well being of my student.

I hereby release and discharge the Department of Education and/or The Georgia Academy for the Blind and its employees and officials from any and all liability in case of accident, injury, damage, or any other mishap in connection with administering and supervising of taking said medication including, but limited to any side effects, illness, or other injury which might occur.

I understand and agree to the following:

- Prescription and over the counter medications provided by me will be in the original container with updated instructions on label.
- The medication form **must** be signed by both parent/guardian and student's attending physician to reduce risk of medication error.
- It is my responsibility to inform the school of any and all changes in student's medication.
- It is my responsibility to provide specific instructions regarding medication or equipment use to Health Services.
- New medication, either prescription or over the counter, will not be given unless a new medication form is completed.
- All medication will be taken directly to Health Services. Students may not keep medication on their person. Exceptions include an inhaler or epi-pen with a physician's written order.

PARENT/GUARDIAN SIGNATURE: _____

STUDENT'S NAME ______________________________________ TODAY'S DATE __________________
DATE OF BIRTH _______________________ ALLERGIES ____________________________________

PLEASE LIST ALL MEDICATIONS, INCLUDING MEDICATION THAT IS TAKEN AT HOME.

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

PARENT/GUARDIAN SIGNATURE: ____
DATE: __________________PHONE NUMBER (BEST ONE TO REACH YOU) ________________________

PHYSICIANS NAME:________________________________OFFICE NUMBER ______________________
ADDRESS: ____
PHYSICIAN'S SIGNATURE: _________________________________DATE _________________________

EMERGENCY HEALTH CARE PLAN

STUDENT _____DATE_____

DATE OF BIRTH _____HEIGHT_____WEIGHT_____

PARENT(S)/GUARDIAN(S)_____

EMERGENCY CONTACT NUMBER(S): please list if cell/work/home and who's number it is

_____

_____

PRIMARY CARE PHYSICIAN:_____PHONE NUMBER:_____

HEALTH INSURANCE/MEMBER ID:_____

DIAGNOSIS:_____ ANY TRIGGERS:_____

ALLERGIES: YES/NO (please circle) If yes, please explain:_____

MEDICATIONS: (please list name, strength, when taken and how taken): _____

_____

_____

_____

_____

SIGNS OF EMERGENCY:_____

_____

_____

ACTIONS FOR SCHOOL STAFF TO TAKE: _____

_____

_____

_____

PHYSICIAN SIGNATURE_____DATE_____

PARENT/GUARDIAN SIGNATURE_____DATE_____

GEORGIA ACADEMY FOR THE BLIND
HEALTH SERVICES RECORD

STUDENT NAME_____ DOB_____ MALE/FEMALE (please circle)

PARENT/GUARDIAN_____RELATIONSHIP_____
(Please print)

ADDRESS_____ CITY_____ ZIP_____

PHONE NUMBERS: _____ HOME _____ CELL
_____WORK

EMAIL ADDRESS: _____

WHAT IS THE BEST WAY TO REACH YOU? (Please circle) HOME/WORK/CELL/EMAIL/OTHER _____

EMERGENCY CONTACTS

NAME _____ RELATIONSHIP _____

PHONE NUMBERS: _____HOME _____ CELL
_____ WORK

WHAT IS THE BEST WAY TO REACH? (Please circle) HOME/WORK/CELL

NAME _____ RELATIONSHIP _____

PHONE NUMBERS: _____ HOME _____ CELL
_____ WORK

WHAT IS THE BEST WAY TO REACH? (Please circle) HOME/WORK/CELL

PRIMARY PHYSICIAN: _____ PHONE: _____
OPTHAMOLOGIST: _____PHONE: _____
NEUROLOGIST: _____PHONE: _____
OTHER: _____PHONE: _____

WHO HAS PERMISSION TO PICK STUDENT UP FROM SCHOOL/CLINIC?

_____
_____
_____

STUDENT'S NAME _____ TODAY'S DATE _____

PERMISSION TO TREAT

I give permission for my child to be treated by the Georgia Academy for the Blind Health Services Nursing staff and consulting Physicians. Services provided include, but are not limited to the following:

- GENERAL PRIMARY NURSING CARE
- NURSING DIAGNOSIS AND TREATMENT OF ACUTE ILLNESSES
- NURSING DIAGNOSIS AND TREATMENT OF CHRONIC ILLNESSES
- REFERRALS FOR ILLNESSES NOT SUITABLE FOR DIAGNOSIS AND/OR TREATMENT BY NURSING STAFF
- BLOOD PRESSURE CHECKS
- BLOOD GLUCOSE CHECKS
- VISION, HEARING AND DENTAL SCREENINGS
- SCOLIOSIS SCREENING
- HEAD LICE SCREENING
- HEALTH EDUCATION FOR STUDENTS AND PARENTS
- NUTRITION EDUCATION
- ADMINISTRATION OF PRESCRIPTION MEDICATION AS ORDERED BY PHYSICIAN
- ADMINISTRATION OF OVER THE COUNTER MEDICATIONS, CREAMS AND OINTMENTS SUCH AS: IBUPORFEN, TYLENOL, MAALOX, TUSSIN DM, NON-PSEUDO SINUS, CLARITIN, MILK OF MAGNESIA, GAVISCON, LOTRIMIN, HYDROCORTISONE, ANTIBIOTIC OINTMENT.

IF FOR ANY REASON YOUR CHILD **CANNOT** TAKE ANY OF THE ABOVE MENTION PLEASE STATE WHICH MEDICATION AND THE REASON: _____
_____
_____

PARENT/GUARDIAN SIGNATURE: _____
DATE: _____

STUDENT'S NAME _____ TODAY'S DATE _____

STUDENT HEALTH HISTORY

DIAGNOSIS: _____

ALLERGIES: (please list allergen, reaction, and treatment)

- FOOD _____
- MEDICATION _____
- INSECTS _____
- OTHER _____

LATEX? YES OR NO (please circle)

Please check all that apply. Past or present history.

_____AUTISM
_____CONSTIPATION/DIARRHEA
_____DIZZINESS/FAINTING
_____SEASONAL ALLERGIES
_____HEADACHE
_____ORTHOPEDIC PROBLEMS
_____BEHAVIOR/MOOD DISORDERS
_____THYROID DISORDER
_____BLOOD DISORDER
_____ HISTORY OF HEART DISASE/HIGH BLOOD PRESSURE
_____RESPIRATORY PROBLEMS (i.e., ASTHMA, TRACHE, etc.)
_____STROKE/MUSCLE WEAKNESS
_____KIDNEY PROBLEMS
_____SEIZURE DISORDER
_____REFLUX DISORDER/VOMITING
_____SKIN PROBLEMS
_____DIABETES. WHAT TYPE? _____
_____SHUNT. LOCATIONS? _____

If yes, please provide an explanation and current treatment. If more space is needed, please attach a separate sheet of paper.

_____
_____
_____
_____

STUDENT'S NAME _____ TODAY'S DATE _____

SELF CARE SKILLS

Please check all that apply. Past or present history.

TRAVEL

_____WALKS INDEPENDENTLY _____WALKS UNAIDED, BUT WITH DIFFICULTY
_____USES A CANE _____REQUIRES PHYSICAL SUPPORT
_____USES ORTHOPEDIC DEVICES, PLEASE LIST: _____
_____USES A WHEELCHAIR _____AIDED _____UNAIDED

EATING

_____NEEDS NO ASSISTANCE
_____NEEDS ASSISTANCE, PLEASE EXPLAIN: _____
_____SPECIAL DIET*, PLEASE EXPLAIN: _____
*If special diet is required, please make sure to fill out Eating and Feeding Evaluation attached.

TOILETING

_____NEEDS NO ASSISTANCE _____SCHEDULE TRAINED
_____NEEDS ASSISTANCE, PLEASE EXPLAIN: _____

COMMUNICATION

Please check all that apply. Past or present history.

____NEEDS A SIGN LANGUAGE INTERPRETER _____USES REGULAR PRINT
____USES LARGE PRINT _____BRAILLE
____VERBAL _____NON-VERBAL

Primary language the student speaks? _____
Primary language spoken at home? _____

HEARING

Please check all that apply. Past or present history.

____DEAF OR HEARING IMPAIRED (If checked, please indicate degree of hearing loss and in what ear and any assistive devices needed)

_____
_____

STUDENT'S NAME _____ TODAY'S DATE _____

VISION

Please check all that apply. Past or present history

_____CATARACTS _____MACULAR DEGENERATIONS _____DETACHED RETINA
_____GLAUCOMA _____DIABETIC RETINOPATHY _____STARGARDTS
_____CMV _____RETINITIS PIGMENTOSA _____USHERS SYNDROME
_____PREMATURITY OF RETINOPATHY
_____TRAUMA, please explain: _____
_____OTHER: _____
_____LOW VISION _____LEGALLY BLIND _____TOTALLY BLIND
_____LIGHT PERCEPTION ONLY
_____CORTICAL VISUAL IMPAIRMENT
_____WEARS GLASSES, please state if for vision or safety reason. _____
_____CONTACT LENSES _____PROSTHESIS, please explain _____

GEORGIA ACADEMY FOR THE BLIND

EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

PART A			
Student's Name		Age	
Name of School	Grade Level	Classroom	
Does the child have a disability? If Yes, describe the major life activities affected by the disability.		Yes	No
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.		Yes	No
		Yes	No
If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.			

PART B
List any dietary restrictions or special diet.
List any allergies or food intolerances to avoid.
List foods to be substituted.
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground Pureed:
List any special equipment or utensils that are needed.
Indicate any other comments about the child's eating or feeding patterns.

Parent's Signature	Date:
Physician or Medical Authority's Signature	Date:

Return to:
Georgia Academy for the Blind
Attn. Melba Smith
2895 Vineville Avenue
Macon, GA 31204-2899

FAX: 478-751-6659

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) _____

Medicines and Allergies: 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? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ 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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

HE0503 9-2681/0410

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		
	Yes	**No**
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

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

	Yes	**No**
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

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

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ 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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 _____

Other information _____