



PART III – PHYSICAL EXAMINATION

(Physical examination form is required each school year dated after May 1 of the preceding school year and is good through June 30th of the current school year)**

NAME _____ Date of Birth _____ School _____

Date of EXAMINATION:					
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
BP	/	Resting Pulse	Vision R 20/	L 20/	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

Medical Practitioner to School Staff (please indicate any instructions or recommendations here)

Emergency medications required on-site Inhaler Epinephrine Glucagon Other: _____

Comments:

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- CLEARED WITHOUT RESTRICTIONS**
- CLEARED WITH FOLLOWING NOTATION:** _____
Cleared **AFTER** documented further evaluation or treatment for: _____
Cleared for **Limited participation** (check and explain "reason" for all that apply): "*Limited Until Date*" when appropriate
- Not cleared for (specific sports) _____ Until Date: _____
Reason(s): _____

NOT CLEARED FOR PARTICIPATION Reason _____

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II – Medical History.

Physician Signature: _____ ('MD, DO, LNP, PA) . Date** _____
Circle one

Examiner's Name and degree (print): _____ Phone Number _____

Address: _____ City _____ State _____ Zip _____

* Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted



PART IV -- ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are not crossed out: basketball, cross country, field hockey, golf, lacrosse, sailing, soccer, softball, squash, swimming/diving, tennis, track & field, volleyball, waterman, other (identify sports). _____

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/she is insured by our family policy with: _____

Name of Medical Insurance Company: _____

Policy Number: _____ Name of Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participating in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

Additionally I give my consent and approval for the above named student's picture and name to be printed in any school or VISAA athletic program, publication or video.

PART V - EMERGENCY PERMISSION FORM

(To be completed and signed by parent/guardian)

STUDENT'S NAME _____ GRADE _____ AGE _____ DOB _____

SCHOOL _____ CITY _____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency

Please list any allergies to medications, etc. _____

Is the student currently prescribed an inhaler or Epi-Pen? _____ List the emergency medication: _____

Is student presently taking any other medication? _____ If so, what type? _____

Does student wear contact lenses? _____ Date of last Tdap or Td (tetanus) shot _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number (where to reach you in emergency) _____

Evening time phone number (where to reach you in emergency) _____

Cell phone _____

☀▶▶ Signature of parent or guardian _____ Date _____

Relationship to student _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

I certify all the above information is correct _____

☀▶▶ Parent/Guardian Signature

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician