Submit this form ONLY (page 7) to the school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____ Date of exam: _____

Birth Sex (M/F): _____ ☐ Medically eligible for girls sports ☐ Medically eligible for boys sports

"Male" means a person belonging to the sex intended to produce the small reproductive cell. "Female" means a person intended to produce the large reproductive cell.

I have reviewed the History Form for the student named on this form and will provide all relevant information below. The information provided below will be used to assist athletic personnel, which may include but is not limited to an athletic administrator, athletic director, and/or athletic trainer, in the supervision and treatment of the student named on this form.

INITIALS of Health Care Professional: _____

Allergies: _____

Medications: _____

Medical Conditions and/or Surgeries: _____

Any relevant YES answers on History Form: _____

MARK ONE:

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

SIGNATURE of Health Care Professional: _____, MD, DO, NP, PA or DC

Health Care Professional License Number: _____