



Carleton Washburne School
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www.winnetka36.org/Washburne

FY 2023-2024

Washburne Athletic Program Medical Clearance

(If your child has had a physical within the last year, a copy of it will be sufficient)

Student's Name _____

Birth Date: _____ Sex: M ___ F ___

Grade Level: _____

Allergies (food, medication or environment): _____

Medications (include inhalers): _____

Medical Conditions which may affect the student's ability to participate in athletics:

Height: _____ Weight: _____ BP: _____

Do you have asthma, if so does exercise cause any breathing difficulties?	YES	NO
Have you ever passed out during or after exercise?	YES	NO
Have you ever been dizzy during or after exercise?	YES	NO
Have you ever had a concussion? If so, provide date	YES	NO
Date of concussion: _____		
Have you ever had chest pain during or after exercise?	YES	NO
Have you ever had high blood pressure?	YES	NO
Have you ever been told you have a heart murmur?	YES	NO
Have you ever had racing of your heart or skipped heartbeats?	YES	NO
Has anyone in your family died of heart problems or a sudden death before age 50?	YES	NO

Date of Examination: _____ (Must be within one year)

Physician Permission: I have examined this student on this date and find him/her to be physically fit for interscholastic athletics.

Physician Signature

Date

Physician Phone

This form must be on file at Washburne School before a student may participate in any athletic practice or event