MSHSAA Medical Eligibility Form (Step 3):

Issued to Student/Parent(s)/Guardian, Taken to/Completed by Healthcare Professional (MD/DO/ARNP/PA/DC), Copy Retained by Healthcare Professional, Returned to School Administration.

Note: This Medical Eligibility form is the form to be used by a healthcare professional (MD/DO/ARNP/PA/DC) for granting a medical release for a student to participate in All Sports – Spirit – Marching Band after the completion of a preparticipation physical evaluation.

Note: The health care professional (MD/DO/ARNP/PA/DC) must complete this form, retain a copy in the patient's files for their records and issue this form to the student/parent.

This Medical Eligibility form MUST be returned to the school.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex assigned at birth (F,M, intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

☐ **Medically eligible for all Sports-Spirit-Marching Band without restrictions for two (2) years.**

☐ **Medically eligible for all Sports-Spirit-Marching Band without restriction for two (2) years with recommendations for further evaluation or treatment of:** _____

_____

☐ **Medically eligible for all Sports-Spirit-Marching Band without restriction for less than two (2) years. Specify reasons and duration of approval:** _____

_____

☐ **Medically eligible for certain Sports-Spirit-Marching Band:** _____

☐ **NOT medically eligible for Sports-Spirit-Marching Band**

☐ **NOT medically eligible pending further evaluation:** _____

I have examined the above-named student and completed the pre-participation physical evaluation. Unless otherwise indicated, the student does not present apparent clinical contraindications to practice and participate in the sport(s) or activities 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 student 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 student (and parents/guardians).

Name of health care professional (Print/Type) _____

Signature of Healthcare Professional (MD/DO/PA/ARNP/DC): _____

Clinic Address _____ City _____ State _____ Zip _____

Telephone _____ Date of Examination _____

Student's Physician _____ Student's Dentist _____