Physical Examination Form

ALL PARTICIPANTS MUST HAVE A PHYSCIAL FORM ON FILE WTH MUHS JUNIOR HILLTOPPERS BEFORE THEY MAY BEGIN PRACTICE! **NO EXCEPTIONS!**

Physical exams taken after April 1, 2025 are valid for two (2) school years; physical examination taken before April 1st is valid only for the remainder of that school year and the following school year. IT IS THE OBLIGATION OF THE PARENTS TO ARRANGE FOR A PHYSCIAL EXAM. YOU MAY GO TO YOUR OWN DOCTOR OR TO A CLINIC OF YOUR CHOICE.

Participant Name: _____ Grade (as of the coming fall): _____ Age:_____

Sex: _____ Date of Birth: _____ School Name: _____

Parent(s) Name: _____Address: _____

Parent 1 Phone: _____ Parent 2 Phone: _____

Other than parent, in case of emergency, contact: _____

Primary Phone: _____ Relation: _____

Emergency Information

Allergies_____

Medications_____

Other Information _____

I hereby give my permission for the above-named student to practice, compete and represent MUHS in Jr. Hilltopper sports.

SIGNATURE OF PARENT/GUARDIAN _____DATE _____

(Have a doctor complete & sign the bottom portion of the form below OR turn in the completed top part with a valid WIAA Medical Eligibility Form)

Examination Facts: Height _____ Weight_____ Pulse_____ Blood Pressure_____

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

  _____
- ☐ Not medically eligible for any sports

I have examined the above-named student 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 exam 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/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*:

_____

Clinic/Hospital: _____

Date of Examination_____