PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

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Revised 4/24

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Gender: _____ Age: _____ Date of Birth: ___/___/_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the CHSAA Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Mental Health

Explain: _____

_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct.

This form is not considered valid unless all sections are complete.