Department of Education

Medical Clearance Form

☐ Medical ☐ Athletics

School:		Grade:	Home Room #:
Name of Child:	Male ☐	Female ☐	DOB:
Home Address:			
Father/Guardian:		**Mother**/Guardian:	
Place of work:		Place of work:	
Phone: Hm: Wk: Cell:		Phone: Hm: Wk: Cell:	

Immunization and TB Status:

*A copy of the **Official Immunization Record** must be attached. Such record must indicate the specific immunization and results of a **TB Skin Test** and dated on which they were received. Refer to **Board Policy 377** for specific requirements.*

Physical Examination:

Height:	Weight:	T-P-R: / /	BP:
Vision RT:	Vision LT:	Hearing RT:	Hearing LT:

Complete Each Item Below	Normal		Describe Findings if Abnormal or Reason for not Examining
	Yes	No	
General appearance			
Skin			
Hair			
Nails			
Eyes: External (Pupil/Cornea)			
Optic Fundus			
Auditory Acuity			
Muscle Balance			
Ears: External			
Auditory Acuity			
Tympanic Membrane			
Nose			
Mouth			
Pharynx			
Larynx			
Speech			
Teeth/Gums			
Neck/Lymph/larynx			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Genital-Urinary			
Muscular Skeletal			
Scoliosis Screening			
Neurological Impressions			
Nutritional Status			
Behavior during Examination			
Other			

Laboratory Test:

Hemoglobin:	Date:	Hematocrit:	Date:

Other Test *Date* *Results* *Other Test* *Date* *Results*

Summary of Findings, Treatments and Recommendations:

Diagnosis/Findings	Advice and Treatment Given	Recommendations and Follow-Up Plan

Child is physically fit to participate in physical education and/or athletic events and related activities: ( ) Yes ( ) No

Examiner (print) *Signature* *Date* *Clinic name* *Contact Number(s)*

To be completed by Parents:

Health History: *Please indicate Age and year on Condition on the space provided below.*

Anemia:	Diabetes:	Heart Disease:	Rheumatic Fever:
Asthma:	German measles:	Hernia (Rupture):	Skin Problem:
Chicken Pox:	Hay Fever:	Measles:	Tuberculosis:
Convulsions:	Hearing Problem:	Mumps:	Vision Problems:

1	Head Injuries	Year:	Results:
2	Fractures	Year:	Results:
3	Previous hospitalization	Year:	Results:
4	Allergies (please list) :		
5	Currently taking medication: ☐ Yes ☐ No		
	Name of medication(s):		
	Reason/Diagnosis:		
6	Disability (specify):		
7	Prosthesis (specify):		
8	Any medical reason why this child should NOT participate in Physical Education or related activities? ☐ Yes ☐ No		
9	Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle etc.) died suddenly before age 50? ☐ Yes ☐ No		
10	Has the athlete ever stopped exercising because of dizziness or passing out during exercise? ☐ Yes ☐ No		
11	Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise? ☐ Yes ☐ No		
12	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? ☐ Yes ☐ No		
13	Does the athlete have a history of concussion (getting knocked out)? ☐ Yes ☐ No		
14	Has the athlete ever suffered a heat-related illness (heat stroke)? ☐ Yes ☐ No		
15	Does the athlete have a chronic illness or see a doctor regularly for any particular problem? ☐ Yes ☐ No		
16	Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries)? ☐ Yes ☐ No		
17	Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? ☐ Yes ☐ No		
18	Has the athlete had surgery or been hospitalized in the past year? ☐ Yes ☐ No		
19	Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? ☐ Yes ☐		
20	Are you, the athlete, worried about any problem or condition at this time? ☐ Yes ☐ No		
Please give details on any "Yes" answer(s) from the above health history.			

Please notify the School Health Counselor or School Administrator if there are any pertinent changes in health status, temporary or otherwise of your child.

Students must submit valid documentation showing completion of a **Physical Examination**, **Immunization** when they are due, results of **TB Skin Test** and **Emergency Information Form**. *(Board Policy 337 Health Requirements)* Students who plan to participate in Interscholastic Activities/Athletics must submit the **Parental Consent** and **Athletic Clearance Form**. **GIAA Rule VII, Student Eligibility, Section-5 Parent Consent/Medical Form**.

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Parent/Guardian (print) *Signature* *Date*

Clearance for Athletics

I have examined student and find the child physically able to participate in the following activities initialed.
For School Year: 20_____ to 20_____

All Activities Listed ☐ *Select each activity if not <u>ALL</u> allowed*. **NO ACTIVITIES** ☐

Basketball ☐	Cross Country ☐	Football ☐	Racquetball ☐	Volleyball ☐
Track & Field ☐	Softball ☐	Soccer ☐	Tennis ☐	Gymnastics ☐
Wrestling ☐	Rugby ☐	Cheerleading ☐	Non-Contact Sport ☐	
Minimum Weight Allowed to Participate if required:			Other *(specify)*	
Further Medical Examination is needed *(specify):*				

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Examiner (print) *Signature* *Date* *Clinic name* *Contact Number(s)*