RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

Last Name	First Name	OSIS#	Grade

School/Campus/ATSDBN

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**

❑ **NOT CLEARED** **Duration:** _____

❑ **NOT CLEARED PENDING FURTHER EVALUATION** **Duration:** _____

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____

❑ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

❑ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

❑ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

❑ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

❑ **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

❑ None ❑ Athletic Cup ❑ Sports/Safety Goggles ❑ Medical/Prosthetic Device ❑ Pacemaker ❑ Insulin Pump/Insulin Sensor
❑ Brace/Orthotic ❑ Hearing Aides ❑ Protective Ear Gear ❑ Other _____

❑ **PERTINENT MEDICAL HISTORY** _____

❑ **ALLERGIES** _____ ❑ None

MEDICATIONS

❑ Has prescribed pre-exercise medication _____

❑ Has prescribed PRN medication _____

❑ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

❑ **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)		Title	License/NPI
Address			Medical Provider's Stamp
Phone	Fax	Email	
Signature of medical provider		Date	