Parker School

Physical Examination and Sports Participation Clearance

Medical History

Parent/Guardian please complete this section and give to attending physician

❑ New Student ***Please Provide TB Clearance and Immunizations Records***

❑ Returning Student ***Please Update Immunization Records***

Student Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street / PO Box City State Zip

Consider the following areas and list all known allergies, medications/supplements currently taking or medical conditions the school should be aware of:

Asthma / Under or Over Weight / Diabetes / Digestive / Heart / Lungs / Musculoskeletal / Vision / Hearing / Emotional Wellbeing / Surgery / Head Aches / Dizziness / Seizures / Infectious Disease / Mood Disorder / Any Other Condition or Concern

_____

_____

_____

Print Parent/Guardian Name(s): _____

Signature:_____ Date: _____

Physician's Examination

Physician's Examination Code: N – Normal A – Abnormal C – Corrected R – Receiving Care

Date	Weight	Blood Pressure	Pulse	Vision	Hearing	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Other _____	Other _____
/ /																			
Please explain A/C/R Codes above:																			

Physician's Recommendation: _____

_____

Sports and School Related Activities Participation Clearance:

I certify that the above student is:

❑ Cleared to participate in all school and sports activities to include interscholastic sports

❑ Requires further evaluation before a final recommendation can be made due to _____

❑ Not Cleared for: ❑ All Sports ❑ Collision/Contact Only ❑ Moderate/High Intensity Only ❑ Other

Due to: _____

Physician Signature:_____ Date of Exam: _____

Print Physician Name: _____ Telephone: _____

Clinic/Office Name and Address: _____