

(You must answer these questions and sign for your child to be examined)

The above is accurate to the best of my knowledge.

I give my permission for my child to be examined for school related activities.

If in the judgment of the school representative, the above named student athlete needs care or treatment for injury or sickness, I do hereby give consent and authorize for such care as may be deemed necessary.

I recognize the evaluation to be done on my child is a standard participation screening examination and that no in depth testing; x-rays, lab work or cardiac testing will be performed.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Student Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Wght: \_\_\_\_\_ Hght: \_\_\_\_\_

SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENTS
Heart				
Lung				
Other				
Abdominal				
Genitalia				
Neck				
Shoulder				
Elbow				
Wrist				
Hand				
Back				
Knee				
Ankle				
Foot				
Eyes	Right 20/	Left 20/	Corrected?	Yes / No

Clearance: \_\_\_\_\_ A. Cleared  
\_\_\_\_\_ B. Cleared after further evaluation/treatment  
\_\_\_\_\_ C. Not cleared for: \_\_\_\_\_ Collision \_\_\_\_\_ Contact \_\_\_\_\_ Non-contact

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of MD: \_\_\_\_\_ Date: \_\_\_\_\_