ATHLETIC MEDICAL ELIGIBILITY FORM

Consent *(To be filled out by parent/guardian)*

Student Athlete Name: _____ Date of Birth: _____ Date of Exam: _____

I acknowledge and give consent for a copy of this form to be kept in the student's school health record and shared with the school in the event that additional medical information is needed/appropriate. Should my student's health change in any way that would impact information in this form and/or participation, I will inform the school as soon as possible.

I release only page 4

Signature of Parent or Guardian: _____ Date: _____

**I understand that I may be asked to release additional health information to the school if needed*

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Student Athlete's Allergies: _____

Student Athlete's Medications: _____

Emergency Contacts:

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____

Participation Eligibility *(To be filled out by medical provider)*

☐ Medically Eligible for sports without restriction.

☐ Medically Eligible for all sports without restriction with recommendations for further evaluation or treatment of:
_____

☐ Medically eligible for certain sports:
_____

☐ Not medically eligible pending further evaluation
_____

☐ Not medically eligible for any sports
Recommendations:
_____

I have examined the student named on this form and completed the preparticipation physical evaluation. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____