Classical Academy High School - Athletic Clearance Form

STUDENT INFORMATION

Name: _____ DOB: _____ Grade: _____

Sports: _____

MEDICAL HISTORY (Completed by student-athlete & parent/guardian prior to exam)

Allergies: _____

Medications: _____

PRE-PARTICIPATION PHYSICAL EXAMINATION (Performed by an approved medical provider: Physician (MD/DO), Physician's Assistant (PA), or Nurse Practitioner (NP) licensed in California).

➢ **Date of Physical Exam**: _____

Height: _____ **Weight**: _____ **Sex**: ▢ Male, ▢ Female

BP: _____/_____ **Pulse**: _____ **Respirations**: _____

PERRL: ▢ Normal, ▢ Abnormal **Vision**: **R** _____ /20, **L** _____ /20 (Corrected ▢ No, ▢ Yes)

Appearance/Skin:	▢ Normal, ▢ Abnormal	**Ongoing medical condition** (asthma, diabetes, etc.)	▢ Yes, ▢ No
Eyes/Ears/Nose/Throat:	▢ Normal, ▢ Abnormal	**Hospitalization or surgery** (in past year)	▢ Yes, ▢ No
Head/Neck/Lymphatics:	▢ Normal, ▢ Abnormal	**Heat illness history**	▢ Yes, ▢ No
Cardiovascular:	▢ Normal, ▢ Abnormal	**Concussion/Head injury**	▢ Yes, ▢ No
Respiratory:	▢ Normal, ▢ Abnormal	**Fainting, chest pain, or irregular heartbeat w/ exercise**	▢ Yes, ▢ No
Gastrointestinal:	▢ Normal, ▢ Abnormal	**Family history sudden cardiac death, or heart disease**	▢ Yes, ▢ No
Genitourinary/Reproductive:	▢ Normal, ▢ Abnormal	**Mental health history** (depression, anxiety…)	▢ Yes, ▢ No
Musculoskeletal:	▢ Normal, ▢ Abnormal	**Disordered eating, or concerns (RED-S)**	▢ Yes, ▢ No
Neurological:	▢ Normal, ▢ Abnormal	**Sickle Cell**	▢ Positive, ▢ Negative, ▢ Unknown

If any "Abnormal" or "Yes", please explain: _____

ATHLETIC CLEARANCE DECISION/MEDICAL ELIGIBILITY (Made by an approved medical provider, after reviewing comprehensive medical history, and completion of the pre-participation physical exam)

I have reviewed the medical history, and conducted a complete physical examination for the above-named student. The athlete does not have any apparent clinical contraindications and **can participate as outlined on this form**. If conditions arise after the athlete has been cleared for participation, the physician may rescind medical eligibility until resolved. I certify that all relevant medical information is included, complete and accurate.

☐ **Unlimited participation: Medically eligible without restriction.**

☐ **Limited Participation**: Medically eligible with restrictions: _____

☐ **Withheld from participation:** Not medically eligible for sports.

SIGNATURES

Provider: _____ ➢ (**Circle**: MD, DO, PA, NP)

License #: _____

➢ **Office Stamp (with Phone and Address):**

_____

➢ **Parent/Guardian Signature** **Student-athlete Signature** **Date**