

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 (pg 2)*
 Returning Student *Please Update Immunization Records (pg 2)*

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: _____ Clinic Name: _____