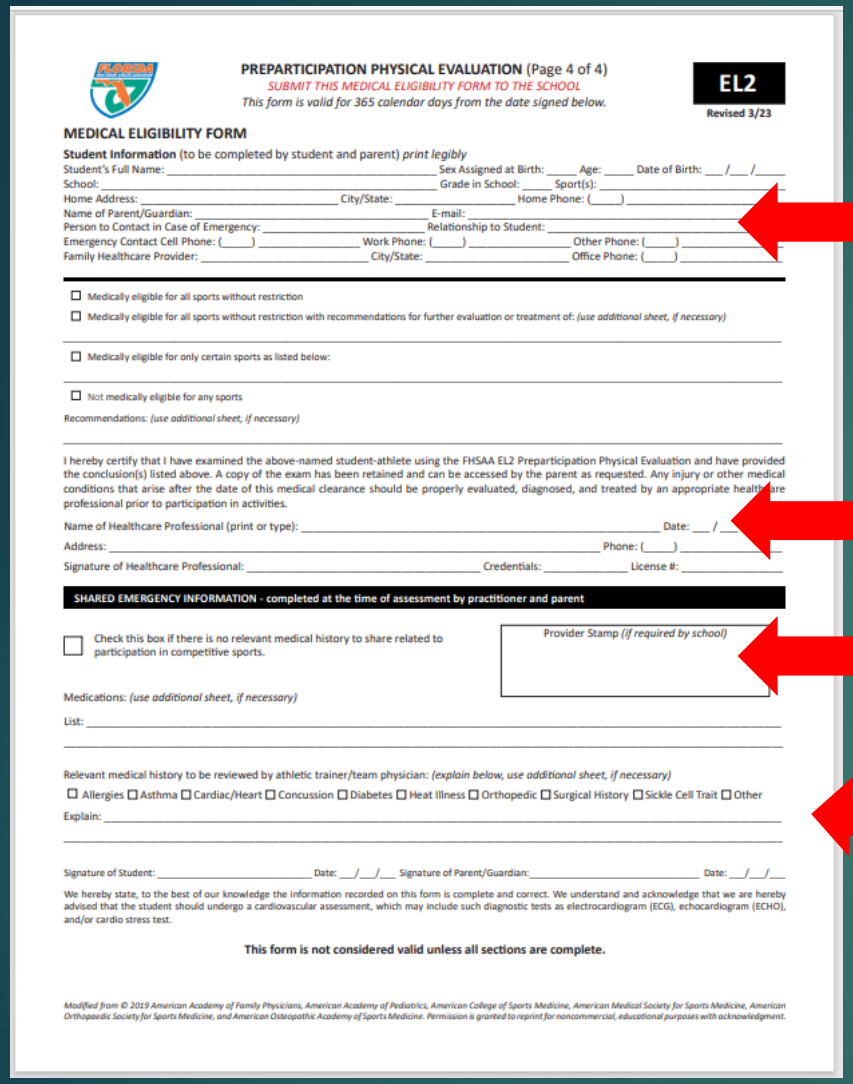

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)
SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL
This form is valid for 365 calendar days from the date signed below.

EL2
Revised 3/23

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

☐ Medically eligible for all sports without restriction
☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*
_____
☐ Medically eligible for only certain sports as listed below:
_____
☐ Not medically eligible for any sports
Recommendations: *(use additional sheet, if necessary)*
_____

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date: ___ / ___
Address: _____ Phone: (____) _____
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*
List: _____
_____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*
☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Other
Explain: _____
_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test.

This form is not considered valid unless all sections are complete.

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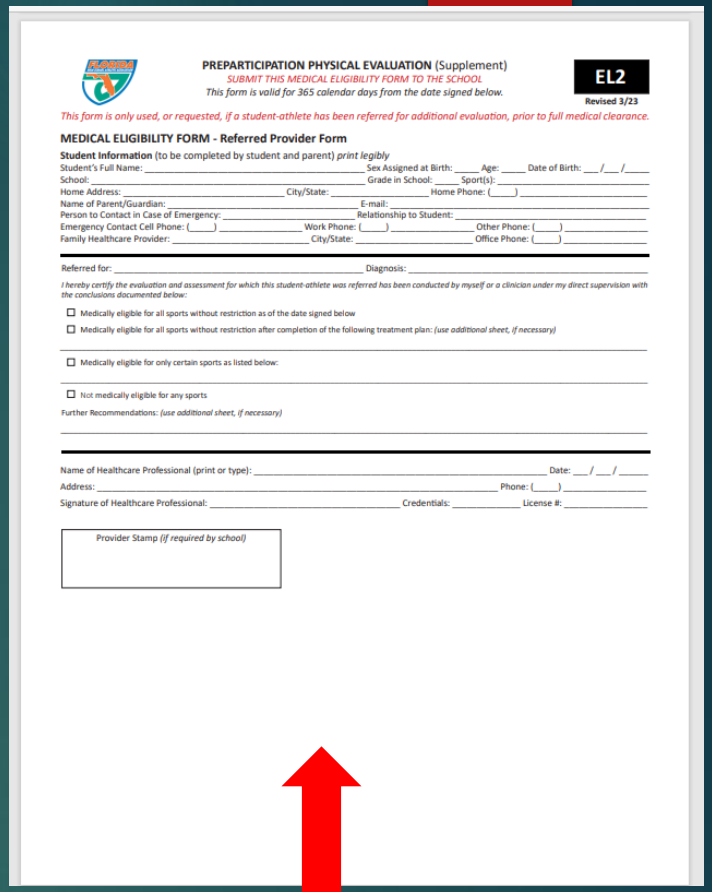
- Student's Information MUST be completed at the TOP!

- Doctor's Name MUST be Printed
- Doctor's Signature & Date
- Doctors Office Address and Phone # (Or Stamp)

This section is if you need to let our Certified Athletic Trainer (ATC) know any pertinent information. Check No if no pertinent information. Information such as allergy, asthma can go here so our ATC is aware.



PREPARTICIPATION PHYSICAL EVALUATION (Supplement)
SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL
This form is valid for 365 calendar days from the date signed below.

EL2
Revised 3/23

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below
☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*
_____
☐ Medically eligible for only certain sports as listed below:
_____
☐ Not medically eligible for any sports
Further Recommendations: *(use additional sheet, if necessary)*
_____

Name of Healthcare Professional (print or type): _____ Date: ___ / ___ / ____
Address: _____ Phone: (____) _____
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*

Only Necessary if Recommendations were made on page 4 and form MUST be completed by specialist listed on recommendation/precauti on etc…