Preparation Physical Evaluation
CLEARANCE FORM

Name: _____ Sex: [ ] M [ ] F Age: _____ Date of Birth: _____

[ ] Cleared for all sports without restriction

[ ] Cleared for all sports without restriction with recommendations for further evaluation or treatment for:
_____
_____

[ ] Not cleared

[ ] Pending further evaluation
[ ] For any sports
[ ] For certain sports _____

Reason: _____

Recommendations:
_____
_____
_____
_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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 physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD. Or DO.

Emergency Information

Allergies: _____

Other Information: _____

PERMISSION AND RELEASE OF PARENT OR GUARDIAN

I, hereby, give my consent for _____ (student) to represent his/her school in the athletic activities except those indicated on this form by the exanimating physician provided that such athletic activities are approved by the State Board of Education or the Georgia High School Association. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips. I understand there exists inherent risks of injury associated with these activities. I authorize the school to obtain through a physician of its own choice, any emergency care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the course of such athletic activities or such travel. I recognize that if I elect to have the above named student examined by the group of voluntary physicians, nurses, or other allied health workers, that the examination cannot be as comprehensive as that performed in a private physician's office and thus may not detect potentially significant health conditions which might be problematic in sports participation. I further release said volunteers (who work without compensation) from any liability if injury should occur.

_____ _____
Printed Name of Parent/Guardian Signature of Parent

_____
Address (H) Phone (W) Phone Date