

PARENTS' PERMISSION FOR SON OR DAUGHTER TO PARTICIPATE IN ATHLETICS

TO: Principal or Superintendent:

As the parents or legal guardian of _____, I give my consent for his/her practice and play in the athletic events listed below and for the physical exam evaluation for that participation. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or emergency treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history on the preceding page is accurate to the best of my knowledge. I understand that the data acquired may be used for research purposes to improve athletic care. I give the South Carolina High School League permission to examine the school records of the above student in order to verify eligibility.

DATE _____

SIGNED _____
(Father, mother, or Legal guardian)

PREPARTICIPATION PHYSICAL EXAM

VITAL SIGNS

HT _____ WT _____
VISION R 20/ L 20/
(CORRECTED)
R 20/ L 20/
CK NEG

(SKINFOLD mm)

DENTAL

RECORD ABNORMALS

R L

PULSES: WRIST

FEM

HEART RATE

BP

CK NEG RECORD ABNORMALS

PHYSICAL

DEFORMITY

APPEARANCE

PUPILS

EENT

LUNG

HEART

ABDOMEN

GU

SKIN

LYMPH NODES

NOTES:

MUSCLSKEL

ROM INSTABIL

C SPINE

T SPINE

LS SPINE

SHOULDER

ELBOW

WRIST

HAND

HIP

KNEE

ANKLE

FOOT

CLEARED (I) _____

CROSS OUT SPORT NOT PERMITTED

FOOTBALL BASKETBALL BASEBALL SOFTBALL VOLLEYBALL WRESTLING FIELD HOCKEY

SOCCER CROSS COUNTRY TRACK TENNIS GOLF BOWLING CHEERLEADING SWIMMING

NEEDS FURTHER EVAL (II) _____ EVALUATION BY _____

REHAB BY _____

SECONDARY CLEARANCE (I) _____ MD or DO Date _____

NOT CLEARED (III) _____

REASON:

COLLISION _____ CONTACT _____ NONCONTACT _____
STRENUOUS _____ MODERATELY STRENUOUS _____ NONSTRENUOUS _____

NAME OF PHYSICIAN OR FACILITY:

ADDRESS:

PHONE:

SIGNATURE _____ MD or DO

Date _____