

LISBON CENTRAL SCHOOL

SPORTS PHYSICAL MEDICAL APPROVAL AND RELEASE FORM

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health examinations.

Student _____ Address _____

Medical Insurance Co/Member ID _____

Grade/Teacher _____ School Year _____ Phone _____

Sports Being Played (1) _____ (2) _____ (3) _____

Height _____ Weight _____ Date of Birth _____

Significant Past Illness or Injury _____

Allergies (Food, Insect Stings, Drugs, etc.) _____ Requires EpiPen _____

Asthma _____ Inhaler/Nebulizer _____

Eyes: R 20 / _____ L 20 / _____ Ears (Hearing Pass/Fail): R _____ L _____

Respiratory _____

Cardiovascular _____ Blood Pressure _____

Liver _____ Spleen _____ Hernia _____

Musculoskeletal/Neurological _____

Completed Immunizations: Polio: _____ Tetanus: _____

Date

Date

In my opinion, _____ is physically able to participate in after school sports.

Physician's Signature

Date of Examination

Name/Address of Physician

Telephone

PARENT AUTHORIZATION

In case of emergency, if family physician cannot be reached, I hereby authorize
_____ to be treated by another physician who is available.

Parent/Legal Guardian

Date

Emergency Numbers for Parents: Home _____ **Work** _____ **Cell** _____

If parent's cannot be reached,
Emergency Contact: _____ **Phone** _____