

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

	Inis	page must be submitt	ea to coa	ch or athletic director before i	PSAL participation.
Last Name	First Name		OSIS#		Grade
School/Campus/ATSDBN					
☐ CLEARED FOR ALL SPORTS WITHOUT RESTRICTION					
□ NOT CLEARED Duration:					
□ NOT CLEARED PENDING FURTHER EVALUATION					
□ CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:					
☐ CLEARED WITH RESTRICTIONS	/ADAPTATIONS/AC	COMMODATION	IS	Duration:	
■ NO CONTACT SPORTS: includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling	fencing, flag footba	NTACT SPORTS: cross-country skiing all, handball, high jur ault, skiing, softball,	,	NO NON-CONTACT SPO archery, badminton, bowli discus, double dutch, golf walking, rifle, shot-put, sw tennis, tennis, track & field	ng, cricket, f, javelin, race vimming, table
☐ OTHER RESTRICTIONS					
ACCOMMODATIONS/PROTECTIVE EQUIPMENT					
□ None □ Athletic Cup □ Sports/Safety Goggles □ Medical/Prosthetic Device □ Pacemaker □ Insulin Pump/Insulin Sensor □ Brace/Orthotic □ Hearing Aides □ Protective Ear Gear □ Other					
□ PERTINENT MEDICAL HISTORY					
□ ALLERGIES □ None					
MEDICATIONS					
☐ Has prescribed pre-exercise medication					
☐ Has prescribed PRN medication					
☐ Student is Self-Carry/Self-Administer, unless in an emergency or student is incapable of self-administration					
Explanation					
□ OTHER RECOMMENDATIONS					
I have examined the above named student and completed the pre-participation physical examination, INCLUDING A REVIEW OF ANY MEDICAL HISTORY RELATED TO COVID-19. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.					
Name of medical provider (print/type)		Title		License/NPI	
Address				Medical Provider's Stamp	
Phone Fax	Email				
Signature of medical provider		Date			