

Lake Washington School District

Middle School Sports Physical Examination Clearance



Student's Name _____
 (Last) (First) (MI)

ASB fee paid: _____
 Sports fee paid: S1 S2 S3 S4
 Family paid: _____

Gender: Male Female Date of Birth _____ Grade _____

Primary parent/guardian _____ Email _____

Primary phone # _____ Secondary Phone # _____

Secondary parent/guardian _____ Email _____

Primary phone# _____ Secondary Phone# _____

Physician _____ Physician Phone _____

Physical Examination/Clearance *(completed by physician only)*

Medications _____
 Vision _____ Height _____ Weight _____
 Eyes _____ BP _____ HR _____ UA _____
 Ears _____ GI / GU _____
 Nose _____ Allergies (food/medicines) _____
 Teeth _____ Skin _____
 Heart _____ Musculoskeletal _____
 Lungs _____ Neurological _____

Do you know any reason why this child should not participate in the athletic programs in the Lake Washington School District?

No Yes If yes, please explain _____

Assessment: Full Participation Limited Participation (describe limitations below)

Physician's signature _____ Date of original exam _____

Health History – check all that apply *(To be completed by parent/guardian)*

Asthma _____ Convulsions _____ Neck or back surgery _____ Contact lenses _____
 Concussion _____ Heart problems _____ False teeth or bridge _____
 Epilepsy _____ Dehydration problems _____ Abnormal bleeding _____
 Sprains/strains/fractures _____
 Anything else _____
 Current medications _____
 Preferred hospital _____

Emergency Contact: (Relative or neighbor) _____ Phone #: _____

Other phone numbers where we can reach you in emergency _____

Insurance Information: I have medical coverage for doctor's services and hospitalization and will continue to keep it in force throughout the sports season. I accept full responsibility for the cost of treatment for any injury my student may suffer while participating in the athletic program.

Insurance Company Name _____ Policy # _____

Medical Authorization: As a parent or legal guardian, I authorize a qualified physician to examine the above named student in the event of an injury to administer emergency care and arrange for any consultation by a specialist, including a surgeon, deemed necessary to ensure proper care of any injury. Every effort will be made to contact the parent or guardian to explain the nature of the problem prior to any involved treatment.

We certify that we have read, understand, and agree to the following:

Athletic Policy w/ Refund Information (student initials) _____ (parent initials) _____
Concussion Sheet- Lysted Law & Sudden Cardiac Arrest (student initials) _____ (parent initials) _____

By signing below I agree that all information provided is true and correct.

 Student signature

 Parent signature

 Date