PHYSICIAN'S STATEMENT

STUDENT'S NAME_____ GRADE_____

SPORTS_____

_____

CURRENT SCHOOL LAST SCHOOL

VERIFICATION OF HOSPITALIZATION INSURANCE

_____IS INSURED BY_____INSURANCE

POLICY #_____

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

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PHYSICIAN'S STATEMENT

(To be completed by examining Physician)

ABSOLUTE CONTRAINDICATIONS:

Three concussions
History of Retinal detachment
Vision in only one eye
Congenital glaucoma
Symptomatic lung infection
Severe mitral stenosis
Cranial swelling following intracranial surgery
Myocarditis
Cyanotic heart disease
Blood coagulation defects
Any enlarged abdominal organ
Symptomatic pulmonary hypertension

RELATIVE CONTRAINDICTATIONS:

Well-controlled epilepsy
Two concussions
Diabetes
Recurrent dislocation of shoulder
Painful Osgood-Schlatter's disease
Active infection of the eye or skin
Severe cystic acne
Amputee
Active herpes simplex (wrestlers only)
Hip disease (arthritis, etc.)
Resting Systolic blood pressure 140 or over and or
Diastolic blood pressure 90 or over
Inguinal hernia
Knee instability
Metabolic bone disease with skeletal weakness

HEIGHT:_____ WEIGHT:_____ RESTING PULSE:_____ BLOOD PRESSURE:_____

VISUAL ACUITY: W/GLASSES – BOTH - R_____ L_____ W/O GLASSES – BOTH - R_____ L_____

I certify that _____ has been examined by me on _____

He/She is physically qualified to participate in contact sports (football, wrestling,, basketball, baseball, soccer) and non-contact sports.

_____ _____ _____

PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE DATE

He/She is disqualified from the following sports:

_____ _____ _____

PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE DATE