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 _____ 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 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:

Refund policy (student initials)_____ (parent initials) _____
Athlete Drug, Alcohol, Tobacco, Hazing & Conduct Codes (student initials)_____ (parent initials) _____
Concussion Sheet- Lysted Law (student initials)_____ (parent initials) _____
Rose Hill Middle School Athletic Handbook (student initials)_____ (parent initials) _____

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

_____ _____ _____
Student signature Parent signature Date

Updated 8/2019