

Malcolm Public Schools CLEARANCE FORM

This section to be completed by a physician

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction
 Cleared, with recommendations for further evaluation or treatment for: _____
 Not cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____ Other Information _____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

- Up to date (see attached documentation) Not up to date Specify _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

© 2004 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

Please complete if applicable:



Give MONTH, DAY, & YEAR of each **NEW** immunization given this year

Type	Date	Date