

**Lake Washington School District**  
**Sports Physical Examination/Clearance Form**  
*For Interscholastic Athletics Registration*

ASB Fee Paid: \_\_\_\_\_  
Sport Fee Pd: S1 S2 S3 S4  
Family Pd: \_\_\_\_\_

Student name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (MI)

Sex:  Male  Female Grade \_\_\_\_\_ Home Phone \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Cell/Office Phone \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

**Physical Examination/Clearance** (To be completed by physician only) Date of original exam \_\_\_\_\_

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 athletic programs in Lake Washington School District?**

No  Yes If yes, please explain \_\_\_\_\_

ASSESSMENT:  Full Participation  Limited Participation (describe limitations below) \_\_\_\_\_

Today's date \_\_\_\_\_ Physician's Signature \_\_\_\_\_

**HEALTH HISTORY:** (To be completed by parent/guardian)

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

**EMERGENCY CONTACT:** (Relative or Neighbor) \_\_\_\_\_ Phone \_\_\_\_\_

Other #'s where in emergency we can reach you \_\_\_\_\_

**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 Co. 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.

**ATHLETIC, DRUG, ALCOHOL, TOBACCO & CONDUCT CODES:** I have read the Lake Washington School District Athletic Codes and will follow the requirements. I hereby give my consent for the student athlete named above to accompany any school team and represent his/her school in athletic events. All the information provided above is correct and true.

**PERMISSION TO SHARE INFO/PHOTOS WITH MEDIA:**  LWSD only  Local News  None

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Date