Dear Parents:

Please read the rules at the bottom of the sheet and then sign the top half of the sheet. Also, detach the bottom for your copy.

We have read and understand the condensed rules of the OCMSAC on this form. We know of no reason why the student should not be eligible to participate in OCMSAC athletics and the student agrees to follow the rules of his/her school and the OCMSAC. We understand the risks that are associated with participating, including serious injury and even death. We voluntarily accept any and all responsibility for the student’s safety while participating and agree to take no legal action against the OCMSAC, the Okaloosa County School District and/or employees and/or representatives of the Okaloosa County School District.

Student signature____________________________________________ Date______________

Parent signature____________________________________________ Date______________

(WHERE DIVORCED OR SEPARATED, PARENT/GUARDIAN WITH LEGAL CUSTODY MUST SIGN)

ATTENTION STUDENT AND PARENT(S)/GUARDIAN(S)

Your school is a member of the Okaloosa County Middle School Athletic Conference (OCMSAC) and follows established rules.

To be eligible to represent your school in interscholastic athletics a student:

1. Must be regularly enrolled and in regular attendance at your school. If the student is a home education student or attends a charter school, the student must declare in writing his/her intention to participate in athletics to the school at which the student is permitted to participate. Home education students must be approved prior to any participation.
2. Must attend school within 10 days of the beginning of each semester to be eligible during that semester.
3. Must maintain a minimum 2.0 grade point average on a 4.0 scale and pass 5 subjects for the grading period immediately preceding participation or student eligibility for the first grading period for each new school year shall be based on passing 5 subjects and maintaining the required GPA for the previous school year. Elementary students initially entering middle school will have their eligibility determined by their first grading period.
4. Must participate at the school in which the student first enrolls (attends), or at which the student first takes part in an athletic practice, at the beginning of the school year.
5. Once a student has been reported for eligibility in a particular activity, he/she may not become eligible in any other activity until the season for the activity in which he/she was reported eligible has ended.
6. Must not participate on a non-school team which is affiliated with a school or coached by a representative of a school other than the one the student attends or has attended and then attend that school, otherwise the student will be ineligible there for one year.
7. Must not transfer to a school that the student’s coach has relocated to within a year, otherwise the student will be ineligible there for one year.
8. The limit of eligibility for each student shall be six (6) consecutive semesters from the time the student initially enters the sixth grade.
9. Must have signed permission to participate from the student’s parent(s)/guardian(s) provided the school.
10. Any student who becomes 15 years of age on or after September 1 may participate in interscholastic athletics during the entire school year so far as age is concerned. However, any student who becomes 15 on or before August 31 shall be ineligible for further participation in interscholastic athletics.
11. Must undergo a preparticipation physical evaluation and be certified as being physically fit for participation in interscholastic athletics. The physical evaluation is valid for 365 calendar days from the date that it was administered after which time the student must successfully undergo another physical evaluation to continue his/her participation.
12. Must be an amateur. This means the student must not accept money, gift or donation for participating in a sport, or use a name other than his/her own when participating.
13. Must display good sportsmanship and follow the rules of competition before, during and after every contest in which the student participates. If not, the student may be suspended from participation for a period of time.
14. Must not provide false information to his/her school.
15. Foreign exchange and international students must be approved by the Okaloosa Middle School Athletic Conference Committee prior to any participation.

**If the student is declared or ruled ineligible due to one or more of the rules of the OCMSAC, the student has the right to request that his/her school file an appeal on behalf of the student. See your principal or athletic director for information regarding this process.**
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Concussion Information

What is a concussion?

Concussion is a brain injury. Concussions, as well as all other head injuries, are serious. They can be caused by a bump, a twist of the head, sudden deceleration or acceleration, a blow or jolt to the head, or by a blow to another part of the body with force transmitted to the head. You can’t see a concussion, and more than 90% of all concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. All concussions are potentially serious and, if not managed properly, may result in complications including brain damage and, in rare cases, even death. Even a “ding” or a bump on the head can be serious. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, your child should be immediately removed from play, evaluated by a medical professional and cleared by a medical doctor.

What are the signs and symptoms of concussion?

Concussion symptoms may appear immediately after the injury or can take several days to appear. Studies have shown that it takes on average 10-14 days or longer for symptoms to resolve and, in rare cases or if the athlete has sustained multiple concussions, the symptoms can be prolonged. Signs and symptoms of concussion can include: (not all-inclusive)

- Vacant stare or seeing stars
- Lack of awareness of surroundings
- Emotions out of proportion to circumstances (inappropriate crying or anger)
- Headache or persistent headache, nausea, vomiting
- Altered vision
- Sensitivity to light or noise
- Delayed verbal and motor responses
- Disorientation, slurred or incoherent speech
- Dizziness, including light-headedness, vertigo(spinning) or loss of equilibrium (being off balance or swimming sensation)
- Decreased coordination, reaction time
- Confusion and inability to focus attention
- Memory loss • Sudden change in academic performance or drop in grades
- Irritability, depression, anxiety, sleep disturbances, easy fatigability
- In rare cases, loss of consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with signs and symptoms of concussion should be removed from activity (play or practice) immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to sustaining another concussion. Athletes who sustain a second concussion before the symptoms of the first concussion have resolved and the brain has had a chance to heal are at risk for prolonged concussion symptoms, permanent disability and even death (called “Second Impact Syndrome” where the brain swells uncontrollably). There is also evidence that multiple concussions can lead to long-term symptoms, including early dementia.

What do I do if I suspect my child has suffered a concussion?

Any athlete suspected of suffering a concussion should be removed from the activity immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from an appropriate health-care professional (AHCP). In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes), or a licensed physician assistant under the supervision of a MD/DO (as per Chapters 458 and 459, Florida Statutes). Close observation of the athlete should continue for several hours. You should also seek medical care and inform your child’s coach if you think that your child may have a concussion. Remember, it’s better to miss one game than to have your life changed forever. When in doubt, sit them out.

When can my child return to play or practice?

Following physician evaluation, the return to activity process requires the athlete to be completely symptom free, after which time they would complete a step-wise protocol under the supervision of a licensed athletic trainer, coach or medical professional and then, receive written medical clearance of an AHCP.

For current and up-to-date information on concussions, visit http://www.cdc.gov/concussioninyouthsports/ or http://www.seeingstarsfoundation.org

Statement of Student Athlete Responsibility

I accept responsibility for reporting all injuries and illnesses to my parents, team doctor, athletic trainer, or coaches associated with my sport including any signs and symptoms of CONCUSSION. I have read and understand the above information on concussion. I will inform the supervising coach, athletic trainer or team physician immediately if I experience any of these symptoms or witness a teammate with these symptoms. Furthermore, I have been advised of the dangers of participation for myself and that of my child/ward.

Name of Student-Athlete (printed) ___________________________ Signature of Student-Athlete ___________________________ Date _______/_______/__________

Name of Parent/Guardian (printed) ___________________________ Signature of Parent/Guardian ___________________________ Date _______/_______/__________
FHSAA Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body’s natural air conditioning, but when a person’s body temperature rises rapidly, sweating just isn’t enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

**Heat Stroke** is the most serious heat-related illness. It happens when the body’s temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

**Heat Exhaustion** is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids.

**Heat Cramps** usually affect people who sweat a lot during demanding activity. Sweating reduces the body’s salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

**Who’s at Risk?**
Those at highest risk include the elderly, the very young, people with mental illness and people with chronic diseases. However, even young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

By signing this agreement, the undersigned acknowledges that the information on page 1 and page 2 have been read and understood.

Name of Student-Athlete (printed)  Signature of Student-Athlete  Date

Name of Parent/Guardian (printed)  Signature of Parent/Guardian  Date
OKALOOSA COUNTY SCHOOL DISTRICT  
RISK MANAGEMENT  
MIDDLE SCHOOL INTERSCHOLASTIC ATHLETICS PARENTAL PERMISSION, RELEASE  
EMERGENCY MEDICAL AUTHORIZATION AND AUTHORIZATION TO RELEASE INFORMATION  

NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN  

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS EMPLOYEES, AGENTS OR ASSIGNS USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM OKALOOSA COUNTY SCHOOL DISTRICT, ITS SCHOOL BOARD, ITS EMPLOYEES, AGENTS OR ASSIGNS IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND OKALOOSA COUNTY SCHOOL DISTRICT, ITS EMPLOYEES, AGENTS OR ASSIGNS HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

No student will be allowed to practice or participate in any organized interscholastic athletic activity until this document is signed, notarized and returned to the school Athletic Department.

Student Name ___________________________________________ Grade ____________________________
Address ________________________________________________ Home Phone ________________________
________________________________________________________Emergency Phone _____________________

PURPOSE: To provide the consent of parents and/or guardians for students to participate in interscholastic activities of the School District and provide a hold harmless and release of liability, to authorize the provision of emergency medical treatment for that student who may become ill or injured during such activities and authorizing the release of protected health information.

PLEASE COMPLETE ALL PARTS

PART I - PARENTAL/GUARDIAN PERMISSION, ACKNOWLEDGEMENT AND RELEASE

A. I, __________________________________ hereby grant permission for __________________________ (the "Student Athlete") to participate at __________________________ School during the school year, and I know of, and acknowledge that my child/ward knows of, the risks involved in interscholastic athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for his/her safety and welfare while participating in athletics. With full understanding of the risks involved, I release and hold harmless my child/ward's school, and the Okaloosa County School District, its School Board, its officers, employees, agents or assigns, of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against the Okaloosa County Middle School Athletic Conference requires all students participating in interscholastic athletics be covered by a medical insurance policy providing a minimum of $25,000 limit for medical expenses. I hereby certify ______________________ is covered by medical insurance providing at least $25,000 for medical expenses. The name of our medical insurance company is ___________________________.

I further certify I will notify the principal of the school this child is attending if there is any change in this insurance coverage, and I will purchase the Student and/or Football insurance offered at the school. (STUDENT AND/OR FOOTBALL INSURANCE MAY BE PURCHASED AT YOUR SCHOOL)

B. I grant the released parties the right to photograph and/or videotape my child/ward and further to use said child's/ward's name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The released parties, however, are under no obligation to exercise said rights herein.

C. I also hereby grant permission for my child/ward to be transported by private automobile and/or School District authorized transportation during the school year in which this release is effective to and from all interscholastic sports events.
PART II – EMERGENCY MEDICAL AUTHORIZATION

In the event reasonable attempts to contact me at __________________________ (Phone numbers) have been unsuccessful, I give my consent for (1) the administration of any treatment deemed necessary by __________________________(Preferred physician) or __________________________(Preferred dentist), or in the event the designated preferred practitioner is not available, by another physician or dentist and (2) the transfer and admission of the child to __________________________(Preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist concurring in the necessity for such surgery are obtained prior to the performance of such surgery. I hereby authorize any treating physicians, including athletic trainers and team volunteer doctors, to provide information to school officials regarding my child’s medical condition or injuries. Facts concerning the child’s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

MEDICAL PROVIDERS MAY ACCEPT A PHOTOCOPY OF THIS SIGNED AUTHORIZATION AS IF IT WERE AN ORIGINAL FOR ALL PURPOSES.

PART III – AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the athletic trainers, sports medicine staff and other health care personnel representing __________________________ School. This protected health information may concern the Student Athlete’s medical status, medical conditions, injuries, prognosis, diagnosis, athlete’s participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics and laboratories, Student Athlete’s coaches, medical insurance coordinators, the school’s Athletic Director and Principal, athletic and/or school administrators, chaplains and/or clergy members, and officials of the Okaloosa County Middle School Athletic Conference. I also authorize the Student Athlete’s coaches and other school staff to release protected health information to the athletic trainers, sports medicine staff and other health care personnel as identified above and to other health care professionals providing services to the Student Athlete. As the parent or guardian of the Student Athlete, I hereby confirm that I have signed this authorization/consent for the disclosure of the Student Athlete’s protected health information voluntarily. I understand that my child’s protected health information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) of the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment I the parent/legal guardian understand that once protected health information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent any time by notifying in writing to the school’s Athletic Director, but if I do, it will not have any effect on the actions the Okaloosa County School officials took in reliance on this authorization/consent prior to receiving the revocation. I understand that I may see and obtain a copy of all protected health information described on this form, for a reasonable copy fee, if I ask for it. I further understand that I may request a copy of this form after I sign it. This authorization/consent expires one year from the date it is signed.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE AND RELEASE OF THE STUDENT ATHLETE’S PROTECTED HEALTH INFORMATION AS STATED.

Concussion & Heat Related Illnesses Information Release Form (EL3CH) must be signed along with this form, PRIOR TO NOTARIZATION, and the terms and conditions of the EL3CH Form are considered incorporated into this Authorization.

BY SIGNING BELOW I VERIFY THAT I HAVE READ, REVIEWED AND COMPLETED ALL THREE(3) PARTS OF THIS PERMISSION AND AUTHORIZATION FORM AND KNOW IT CONTAINS A RELEASE.

Date __________________________ Printed Name of Parent or Guardian __________________________ Signature of Parent or Guardian __________________________

STATE OF FLORIDA-COUNTY OF OKALOOSA

The foregoing instrument was acknowledged before me this __________________________ by __________________________

Date __________________________ Name of Person Acknowledged __________________________

Who is personally known to me or who has produced __________________________ as identification and who did/did not take an oath ______

Type of identification __________________________

Signature of Notary Taking Acknowledgment __________________________

Name of Notary (Typed, Printed or Stamped) __________________________

Notary Expiration: __________________________
Part 1. Student Information (to be completed by student or parent)

Student’s Name: ________________________________ Sex: ______ Age: ______ Date of Birth: ______/_____/_______

School: ____________________________________________ Grade in School: ______ Sport(s): ________________________

Home Address: ___________________________________________ Home Phone: (______) _____________

Name of Parent/Guardian: ___________________________________________ E-mail: ______________________________

Person to Contact in Case of Emergency: __________________________________________________________

Relationship to Student: ___________________________ Home Phone: (______) _____________ Work Phone: (______) _____________ Cell Phone: (______) _____________

Personal/Family Physician: ___________________________________________ City/State: ___________________________ Office Phone: (______) _____________

Part 2. Medical History (to be completed by student or parent).

Explain “yes” answers below. Circle questions you don’t know answers to.

1. Have you had a medical illness or injury since your last check up or sports physical? ________

2. Do you have an ongoing chronic illness? ________

3. Have you ever been hospitalized overnight? ________

4. Have you ever had surgery? ________

5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? ________

6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? ________

7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? ________

8. Have you ever had a rash or hives develop during or after exercise? ________

9. Have you ever passed out during or after exercise? ________

10. Have you ever been dizzy during or after exercise? ________

11. Have you ever had chest pain during or after exercise? ________

12. Do you get tired more quickly than your friends do during exercise? ________

13. Have you ever had racing of your heart or skipped heartbeats? ________

14. Have you had high blood pressure or high cholesterol? ________

15. Have you ever been told you have a heart murmur? ________

16. Has any family member or relative died of heart problems or sudden death before age 50? ________

17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? ________

18. Has a physician ever denied or restricted your participation in sports for any heart problems? ________

19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? ________

20. Have you ever had a head injury or concussion? ________

21. Have you ever been knocked out, become unconscious or lost your memory? ________

22. Have you ever had a seizure? ________

23. Do you have frequent or severe headaches? ________

24. Have you ever had numbness or tingling in your arms, hands, legs or feet? ________

25. Have you ever had a stinger, burn or pinched nerve? ________

26. Have you ever become ill from exercising in the heat? ________

27. Do you cough, wheeze or have trouble breathing during or after activity? ________

28. Do you have asthma? ________

29. Do you have seasonal allergies that require medical treatment? ________

30. Do you use any special protective or corrective equipment medical devices that aren’t usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)? ________

31. Have you had any problems with your eyes or vision? ________

32. Do you wear glasses, contacts or protective eyewear? ________

33. Have you ever had a sprain, strain or swelling after injury? ________

34. Have you broken or fractured any bones or dislocated any joints? ________

35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? ________

If yes, check appropriate blank and explain below:

- Head
- Elbow
- Hip
- Neck
- Forearm
- Thigh
- Back
- Wrist
- Knee
- Chest
- Hand
- Shin/Calf
- Shoulder
- Finger
- Ankle
- Upper Arm
- Foot

36. Do you want to weigh more or less than you do now? ________

37. Do you lose weight regularly to meet weight requirements for your sport? ________

38. Do you feel stressed out? ________

39. Have you ever been diagnosed with sickle cell anemia? ________

40. Have you ever been diagnosed with having the sickle cell trait? ________

41. Record the dates of your most recent immunizations (shots) for:

   - Tetanus: ________
   - Hepatitis B: ________
   - Measles: ________
   - Chickenpox: ________

42. When was your first menstrual period? ________

43. When was your most recent menstrual period? ________

44. How much time do you usually have from the start of one period to the start of another? ________

45. How many periods have you had in the last year? ________

46. What was the longest time between periods in the last year? ________

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: ___________________________________________ Date: ______/_____/_______

Signature of Parent/Guardian: ___________________________________________ Date: ______/_____/_______

(WHERE DIVORCED OR SEPARATED, PARENT/GUARDIAN WITH LEGAL CUSTODY MUST SIGN)
**Part 3. Physical Examination** (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student’s Name: ___________________________ Date of Birth: _____ / _____ / _____


Temperature: ___________ Hearing: right: P ___________ F ___________ left: P ___________ F ___________

Visual Acuity: Right 20/_________ Left 20/_________ Corrected: Yes No Pupils: Equal ___________ Unequal ___________

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<th>ABNORMAL FINDINGS</th>
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* – station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

Disability: ___________________________ Diagnosis: ___________________________

____ Precautions: ___________________________

____ Not cleared for: ___________________________ Reason: ___________________________

____ Cleared after completing evaluation/rehabilitation for:

Referred to: ___________________________ For: ___________________________

Recommendations: ___________________________

Name of Physician/Physician Assistant/Nurse Practitioner (print): ___________________________

Address: ___________________________

________________________________________________________________________________

Signature of Physician/Physician Assistant/Nurse Practitioner ___________________________ Date ___________________________
This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

**ASSESSMENT OF PHYSICIAN TO WHOM REFERRED**

I hereby certify that the examination(s) for which referred was/were performed by me or an individual under my direct supervision with the following conclusion(s):

- ___ Cleared without limitation

- ___ Disability: ____________________________ Diagnosis: ____________________________

- ___ Precautions: _____________________________________________________________________________

- ___ Not cleared for: ____________________________ Reason: ____________________________

- ___ Cleared after completing evaluation/rehabilitation for: _____________________________________________________________________________

Recommendations: _______________________________________________________________________________________________________________________

Name of Physician (print): _________________________________________________________________________________________________________________

Address: _______________________________________________________________________________________________________________________________

: ____________________________ Signature of Physician ____________________________ Date