# INTERIM MEDICAL FORM

Students are required to have a preparticipation physical examination completed every two years prior to the first practice of any sport. The examination must be certified by a licensed medical professional acting within the scope and limitations of their practice. Physical exams conducted after May 1st are valid for the **following two years**. Physical exams conducted prior to May 1st are valid only for the remainder of that school year and the following year. An interim history form is required during the off years and must be submitted to the school prior to first practice.

Athlete Name:_____Gender:_____ Grade:_____ Date of Birth:_____
Home Address:_____ Phone Number:_____
Parent/Guardian Name:_____ Current School:_____

## MEDICAL HISTORY

Since last physical exam has this student?

| | | Yes | No |
|---|---|---|---|
| 1. | Had surgery? | ☐ | ☐ |
| 2. | Been hospitalized? | ☐ | ☐ |
| 3. | Had a serious Illness? | ☐ | ☐ |
| 4. | Had an injury requiring a physician's care? | ☐ | ☐ |
| 5. | Been diagnosed with a concussion? | ☐ | ☐ |
| 6. | Started taking any new medications? | ☐ | ☐ |
| 7. | Developed any new allergies? | ☐ | ☐ |
| 8. | Developed any health problems? | ☐ | ☐ |

Explain YES answers:_____
_____
_____

## CONSENT FORM

1. I certify that the information provided above is accurate to the best of my knowledge. I also attest that the above student has been evaluated, treated and/or received clearance by an appropriate medical provider for any questions answered yes above and does not have any medical conditions that would restrict them from participating in athletics this school year.
2. I hereby give my consent for the above student to engage in approved athletic activities as a representative of their school. I also give my permission for the team physician, athletic trainer or other qualified personnel to have access to information provided here and may be disclosed to other school personnel involved in the medical care of this student.
3. I give my consent to necessary medical services, first aid and emergency medical care that may be required in the event of injury while at a school-sanctioned activity. If emergency medical treatment is required and the parent(s) or guardian cannot be contacted, I hereby consent for the above-named student to be given medical care by the doctor or hospital selected by the school.

Name of Athlete (Printed)_____ Athlete Signature_____

Name of Parent/Guardian (printed)_____

Parent or Guardian Signature_____ Date_____

**The original copy of this form MUST be returned to the school.**