BOSTON PUBLIC SCHOOLS

Department of Athletics

Sports Participation Clearance Form

To be completed for initial clearance and post injury

Last Name (student) : _____ First Name: _____

School: _____Student #: _____ Grade: _____Age: _____ Date of Birth: _____

Please check appropriate box	√	Please check appropriate box (not cleared for)	√
Initial Assessment		All sports	
Cleared without restriction		Certain Sports	
Cleared, with restrictions (attach relevant document)		Reason:	
Post injury/illness assessment			

Relevant Medical Information for Coaches and BPS Athletic Department

Allergies: _____ Epi Pen Necessary (circle one): Yes No

Concussion Hx (circle one): Yes No Number of previous concussions: _____

Asthma (circle one): Yes No Emergency Medications: _____

Diabetes (circle one): Yes No Emergency Medications: _____

Seizure Disorders (circle one) : Emergency Medications: _____

Date of most recent Physical Examination: _____

Comments:

Name of Practitioner (print/type) :_____

Practitioner Phone #: and/or contact information: _____

Signature of School Nurse (required for clearance): _____