

Beatrice Middle and High School
Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of Birth _____

Ht _____ Wt _____ B/P _____

Cleared without restriction

Diagnosis of Asthma? Yes ___ No ___ (If yes, please attach copy of Asthma Action Plan. *Must have Dr.'s signature.)

****All students with a diagnosis of asthma must have an AAP on file with the school nurse.*

Allergies: _____

Cleared, with recommendations for further evaluation or treatment for: _____

Not cleared for All Sports Certain Sports _____ Reason: _____

Name of Physician (print/type) _____ Date: _____

Address _____ Phone: _____

Signature of Physician _____