PARENT SIDE

The Quaker School at Horsham
250 Meetinghouse Road, Horsham, PA 19044

Student Athletic Physical Clearance and Participation Form

This form is to be filled out completely and filed in the office before the student may participate in the school athletic programs and school activities.

STUDENT: ____ GRADE __________

First Middle Last

STUDENT'S ADDRESS: ____

CITY: _________________________ STATE: _________ ZIP: ________

PARENT'S NAME: ____

PHONE # ____

PARENTAL PERMISSION

As a parent or legal guardian of the student listed above, I hereby give my consent for him/her to participate in the following athletic events and/or school activities (please check):

_____ Physical Education
_____ Yoga
_____ Ice Skating
_____ Special Equestrians
_____ Field Day
_____ Cross Country
_____ Softball

I also grant permission for transportation to the nearest medical facility and any treatment deemed necessary for conditions arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

Parent/Guardian Signature: ____________________________ Date: _____________

Please have your physician fill in the form on the back.

PHYSICIAN SIDE

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name: ______________________________ Sex: M F Age: ______ Date of Birth: ___________

___ Cleared for all sports and school activities without restrictions

___ Cleared for all sports and school activities with the following restrictions (please list):

____

____

___ Not cleared

___ Pending further evaluation

___ For any sports/school activities

___ For certain sports/school activities:____

Reason ____

Recommendations ____

____

I have examined the above-named student and completed the pre-participation physical evaluation. If injuries occur while participating, the student will need to be reevaluated and any restrictions will be noted.

Name of the physician (print/type) ____

Date: _________________________ Phone _____________________________________

Address ____

Signature of physician ____