

Audubon Charter School --- Sports Medical Release Form

719 Carrollton Avenue *New Orleans, La 70118 *(504) 324-7110 * 504-218-4618 (fax)

| | | | |
|----------------|--|-----------------|--|
| Student's Name | | Student's Grade | |
|----------------|--|-----------------|--|

On the basis of the examination on this day, I approve this child's participation in:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Soccer | <input type="checkbox"/> Track/Field Cross Country |
| <input type="checkbox"/> Flag Football | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Cheerleading |
| <input type="checkbox"/> Golf | | |

Good for school year _____

| |
|-------------------------------------|
| Physician's Name _____ |
| Signature _____ |
| Date _____ Address _____ |
| Parent's Signature _____ Date _____ |

Athletic Director's Signature: _____ Date: _____

Coach's Signature: _____ Date: _____

Audubon Charter Athletics Preparticipation Physical Evaluation

| | |
|-----------------------|--|
| STUDENT NAME: | |
| Date of Birth: | |
| Sport: | |

| | NORMAL | ABNORMAL FINDINGS |
|---|---------------------|----------------------------|
| Ear, Nose Throat | | |
| Heart (Auscultate in Supine & Standing) | | |
| Chest & Lungs | | |
| Skin & Lymphatic | | |
| Abdominal | | |
| Genitalia & Hernia | | |
| Neck | | |
| Shoulders | | |
| Elbows | | |
| Wrists | | |
| Hands | | |
| Back | | |
| Knees | | |
| Ankles | | |
| Feet | | |
| Flexibility | | |
| Height _____ | BP _____ / _____ | Vision: R 20/ _____ |
| Weight _____ | Pulse _____ | L 20/ _____ |
| Age _____ | Rate Regular? _____ | Corrected? Y _____ N _____ |
| | | Pupils: Equal Unequal |
| Clearances | | |

- A. Full Clearance** _____
- B. Cleared after completing evaluation/rehabilitation for** _____
- C. Not Cleared For: Collision/ Contact** _____
- Non-Contact** _____
- Strenuous** _____
- Mod. Strenuous** _____
- Non-Strenuous** _____

Due To: _____

Recommendations _____

| | |
|---|------------|
| I certify that I have on this date examined this student and that, on the basis of the requested the this examination and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to participate in supervised athletic activities .(Note exceptions above) | |
| Physician, A.N.P. or P.A. Signature: _____ | |
| Date: _____ | (Required) |