Delavan Christian School
848 Oak Street, Delavan, WI 53115
(262) 728-5667

Student Sport Physical Exam Report 2024-2025

To be filled out by family physician – must return form to school office before first game.

Student name (Last) _____ (First) _____ (Middle Initial) _____

Date of Birth _____ Age _____ Sex (F or M) _____ Grade _____

Present Address _____

Telephone _____ Height: _____ Weight: _____

Eye Health: Right _____ Left _____

Vision: Right _____ Left _____

Ears: Right _____ Left _____

Allergies (list): _____

Nose: _____

Mouth and Throat: _____

Neck: _____

Lymph Glands: _____

Heart: _____

Lungs: _____

Abdomen: _____

Hernia: _____

Skin: _____

Urine: _____

Hemoglobin: _____

Posture: _____

Neuro-Muscular: _____

Emotional Stability: _____

Summary of Defects: _____

_____

_____

Remarks and Recommendations: _____

_____

_____

Any Limitation of Activities: _____

_____

_____

Is student on medication: _____

If so, what kind and dosage: _____

_____

_____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports _____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical exam findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of health care professional (Print/Type) _____

SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP:

_____

Clinic Name _____

Address/Clinic _____

City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

Parents' Place of Employment _____

Family Physician _____

Family Dentist _____

Name of Private Insurance Carrier _____

Telephone _____

Emergency Information Allergies _____

Medications _____

Other Information _____

Immunizations ☐ Up to date (see attached documentation) ☐ Not up to date - specify _____

(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school approved interscholastic sports except those restricted on this form.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as “HIPAA”), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____