2016-2017 SPORTS QUALIFYING PHYSICAL EXAMINATION CLEARANCE FORM
Minnesota State High School League

Student Name: ____________________________  Birth Date: __________  Age: ______  Gender: M / F
Address: ________________________________________________________________
Home Telephone: ______ - ______ - ________   Mobile Telephone ______ - ______ - ________
School: ____________________________  Grade: ______  Sports: ____________________________

I certify that the above student has been medically evaluated and is deemed to be physically fit to:

[ ] (1) Participate in all school interscholastic activities without restrictions.
[ ] (2) Participate in any activity not crossed out below.

[ ] (3) Requires further evaluation before a final recommendation can be made.
Additional recommendations for the school or parents: ____________________________
____________________________________________________________________________

[ ] (4) Not cleared for: [ ] All Sports  [ ] Specific Sports __________
Reason: ___________________________________________________________________
____________________________________________________________________________

I have examined the above named student and completed the Sports Qualifying Physical Exam as required by the Minnesota State High School League. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents.

Attending Physician Signature ____________________________________________  Date of Exam ______
Print Physician Signature ________________________________________________
Office/Clinic Name ____________________________________________  Address: ____________________________
City, State, Zip Code ______ - ______ - ________  E-Mail Address: ____________________________

IMMUNIZATIONS [Tdap; meningococcal (MCV4, 1-2 doses); HPV (3 doses); MMR (2 doses); hep B (3 doses); varicella (2 doses or history of disease); polio (3-4 doses); influenza (annual)]
[ ] Up-to-date (see attached school documentation)  [ ] Not up-to-date / Specify_

IMMUNIZATIONS GIVEN TODAY: __________________________

EMERGENCY INFORMATION
Allergies ____________________________
Other Information ____________________________
Emergency Contact: ____________________________________________  Relationship __________
Telephone: (H) ______ - ______ - ________ (W) ______ - ______ - ________ (C) ______ - ______ - ________
Personal Physician ____________________________________________  Office Telephone ______ - ______ - ________

This form is valid for 3 calendar years from above date with a normal Annual Health Questionnaire.
FOR SCHOOL ADMINISTRATION USE: [ ] [Year 2 Normal]  [ ] [Year 3 Normal]
