Cedar Rapids Community School District

MEDICAL ELIGIBILITY FORM
ATHLETICS/SANCTIONED ACTIVITIES

Student Participant Legal Name: _____ **Date of Birth:** _____

Student Preferred Name: _____ **Sex:** M F **Gender:** M F NB

I acknowledge and give consent for a copy of this entire form to be kept in the student's athletic/activity record. I agree that should student's health change in any way that would alter this form, I will inform the athletic/activities office, school nurse and update health information in Infinite Campus as soon as possible.

Signature of Parent or Guardian: _____ **Date:** _____

Shared Emergency Information *(To be completed by athlete/athlete's parent/guardian. Any health information which has not been entered into Infinite Campus during registration will be shared with the school nurse)*

Allergies:

_____

Medications:

_____

Other Information:

_____

Participation Eligibility ***(To be completed by licensed medical provider only)***

Date of Physical Exam: _____

☐ Medically Eligible for sports/sanctioned activities without restriction.

☐ Medically Eligible for all sports/sanctioned activities without restriction with recommendations for further evaluation or treatment of:

_____

☐ Medically eligible for certain sports/sanctioned activities:

_____

☐ Not medically eligible pending further evaluation:

_____

☐ Not medically eligible for any sports

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s)/activities as outlined in this form. If conditions arise after the student has been cleared for participation, the provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the student (and parents or guardians).

Name of health care professional (print): _____ **Date**:_____

Clinic Name: _____ **Phone:** _____

Signature of licensed health care professional: _____

(Iowa law does not allow this form to be signed by RN's, CNA's, CMA's or other office staff as a proxy for the provider):