Well Exam - Sports Participation Clearance Form

NOTE: How often a clearance form is needed to play sports, is determined by your school. This clearance form is the only Sports Participation Clearance Form supported by the Vermont Principals' Association, the Vermont Departments of Health and Education, and the Vermont Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. The American Academy of Pediatrics Council on Sports Medicine and Fitness developed the research based screening activities done during a Well Exam, to determine sports readiness.

Student's Name ________________________________________________________________
Age ___________ Date of Birth _______________  Grade _______________
This Athlete is:
□ Cleared without restriction
□ Cleared, with restrictions:
________________________________________________________________________
□ Not cleared for:  □ All sports
                     □ Certain sports: ____________________________________________
Reason: _______________________________________

Relevant Medical Information for Coaches and Athletic Department:

Allergies: ___________________________________________  EpiPen Necessary: Yes □  No □
Asthma: Yes □  No □  Emergency Medications: _________________________________
Diabetes: Yes □  No □  Emergency Medications: ________________________________
Seizure Disorder: Yes □  No □  Emergency Medications: _________________________
Well Exam using ICD-9-CM code:
□ 99383 or 99393    □ 99384 or 99394    □ 99385 or 99395
5 - 11 years        12 - 17 years        18 - 39 years

NOTE: Clearance form is not valid unless one of these Well Exam codes is checked by Practitioner

Comments: _______________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Name of Practitioner (print/type):__________________________________________ Practitioner Phone #________________
Signature of Practitioner: ____________________________________________ Date of Exam: ____/____/____

Suggestion for Athletic Department: Please make copy for School Nurse's Office records

9/09