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 Provider

Comments: _______________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Reason: _______________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Name of Provider (print/type): ___________________________  Provider Phone # ____________

Signature of Provider: ___________________________  Date of Exam: ___/___/_____

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