MEDICAL ELIGIBILITY SUPPLEMENTAL FORM

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is only required one time if used as a supplement to the EL1.

This form is valid for 365 calendar days from the date of exam if used as a supplement to the EL2.

EL1/2S

Revised 1/26

MEDICAL ELIGIBILITY SUPPLEMENTAL FORM - Referred Provider Form

The Medical Eligibility Supplemental Form is required when a student must obtain further evaluation by a qualified medical specialist prior to clearance for participation in interscholastic athletics.

This form supplements eligibility documentation for referrals originating from either the EL1 - ECG Screening Form or the EL2 - Preparticipation Physical Evaluation. This form documents the specialist's evaluation, recommendations, and clearance status related to the medical concern identified during the initiatl screening/evaluation.

Completion of all applicable sections by the appropriate specialist is required before athletic clearance may be granted.

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ___ /___ /_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

_____

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*