AIKEN COUNTY PUBLIC SCHOOLS

Athletic Participation Form for Athletes with Chronic Medical Conditions

Student Athlete: _____ Date of Birth: _____

Sport(s): _____

Diagnosed chronic medical condition(s):

_____

_____

_____

I have discussed the risk factors related to COVID19 and athletic participation with the physician treating my student athlete for the above condition(s).

_____ _____

Parent's signature Printed name of parent

_____

Date

****

TO BE COMPLETED BY PHYSICIAN:

Please check:

_____ Student athlete is cleared for participation in the sports listed above without restrictions

_____ Student athlete may participate with restrictions: _____

_____

_____ Student athlete's medical condition places him/her at greater risk of complications from COVID19 and therefore he/she should NOT participate in athletic programs until next evaluation

_____

Physician's Signature

_____

Physician's Telephone

_____

Date

Insert physician's name and address stamp

6/8/2020