WBS KNIGHTS PHYSICAL EXAMINATION CLEARANCE TO PLAY FORM

All players in the Wilkes-Barre/Scranton Knights youth ice hockey program must have this form on file with the program prior to starting the season. The form must be completed by a physician or physician extender (PA-C/NP) prior to every new season. A physical examination performed within the past 18 months is deemed sufficient for authorizing clearance to play on this form.

ATHLETE'S NAME:_____ DOB:_____
AGE:_____ SEX: M / F HEIGHT:_____WEIGHT:_____
ADDRESS:_____
PARENT/GUARDIAN NAME:_____PHONE NUMBER:_____
EMERGENCY CONTACT:_____PHONE NUMBER:_____
DENTIST'S NAME:_____PHONE NUMBER:_____
DOCTOR'S NAME:_____PHONE NUMBER:_____
INSURANCE COMPANY:_____
POLICY NUMBER:_____
ALLERGIES:_____
MEDICATIONS:_____
MEDICAL CONDITIONS:_____

Physician's Recommendations and Examination
The above named player has been examined and there are no apparent restrictions to participation in interscholastic athletic activities except as follows:

[ ]CLEARED WITHOUT RESTRICTION TO PLAY ICE HOCKEY
[ ]CLEARED WITH THE FOLLOWING QUALIFICATIONS:_____
[ ]NOT CLEARED - REASON:_____
PHYSICIAN NAME (PRINT):_____
DATE SIGNED:_____DATE OF LAST PHYSICAL EXAM:_____

PHYSICIAN SIGNATURE:_____

My/Our child wishes to participate in youth ice hockey for the Wilkes-Barre/Scranton Knights during the 2024-2025 season.
I/We realize that there are numerous risks involved in participating in the above in the above listed sport. These risks could involve but are not limited to: sprains, contusions, broken bones, lacerations, concussions, permanent disability, internal injuries, paralysis and possible death. These risks could impair my/our child's future ability to earn a living, engage in business, social, recreational activities, and to generally enjoy life. I/We have been informed about the various risks associated with our child's participation in the above listed sports and the potential injuries that may occur.
I/We will assume all responsibility and certify our/my child is in good physical condition and has undergone a sports physical in the past two (2) years. Further, I/we are unaware of any medical condition that would inhibit my/our child's participation except as noted on the Physician's Report. As a condition of our child's voluntary participation in the above-mentioned sports, I/we agree to accept all the previously mentioned risks as a condition of my/our child's participation.
I authorize the coaching staff to provide emergency medical treatment of any injury or illness of my child if qualified medical personnel consider treatment necessary. I further authorize any qualified licensed physician to render medical treatment which in his or her judgement may be deemed necessary in the care of my child.
I acknowledge I have received and read a copy of this organization's HIPPA statement. My signature below indicates I agree with the terms, conditions, and authorizations noted in the HIPPA statement.

PARENT SIGNATURE:_____DATE:_____