

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answer to.

PART II - MEDICAL HISTORY

MEDICAL HISTORY OF STUDENT & FAMILY		MEDICAL HISTORY OF STUDENT & FAMILY	
1.	2.	32.	33.
Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>
Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	Have you ever had herpes skin infection?	<input type="checkbox"/>
Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	<input type="checkbox"/>	Have you ever had a head injury or concussion?	<input type="checkbox"/>
Do you have allergies to medicines, pollen, foods or stinging insects?	<input type="checkbox"/>	Date of last head injury or concussion:	<input type="checkbox"/>
Do you have prescriptions for use of epinephrine, adrenaline, inhaler, or other allergy medications?	<input type="checkbox"/>	Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>
Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	Have you ever been knocked unconscious?	<input type="checkbox"/>
Have you ever had disorientation, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	Have you ever had a seizure?	<input type="checkbox"/>
Have you ever had to stop running after 1/4 to 1/2 mile for chest pain or shortness of breath?	<input type="checkbox"/>	Do you have headaches with exercise?	<input type="checkbox"/>
Does your heart race or skip beats during exercise?	<input type="checkbox"/>	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>
Has a doctor ever told you that you have (check all that apply):	<input type="checkbox"/>	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Urten exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>
A heart murmur	<input type="checkbox"/>	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>
Heart?	<input type="checkbox"/>	Have you had any other blood disorders or anemia?	<input type="checkbox"/>
Has anyone in your family died suddenly for no apparent reason?	<input type="checkbox"/>	Have you had any problems with your eyes or vision?	<input type="checkbox"/>
Does anyone in your family have a heart problem?	<input type="checkbox"/>	Do you wear glasses or contact lenses?	<input type="checkbox"/>
Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	<input type="checkbox"/>	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>
Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	Are you happy with your weight?	<input type="checkbox"/>
Have you ever spent the night in a hospital?	<input type="checkbox"/>	Are you trying to gain or lose weight?	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	Do you limit or carefully control what you eat?	<input type="checkbox"/>
Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	<input type="checkbox"/>	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>
Have you had any breaks or fractured bones or dislocated joints?	<input type="checkbox"/>	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>
Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	What is the date of your last Tetanus immunization? Date: _____	<input type="checkbox"/>
Have you ever had a stress fracture?	<input type="checkbox"/>	FRANCHISE ONLY	<input type="checkbox"/>
Have you ever had an x-ray of your neck for athletic-related instability? Or have you ever been told that you have that disorder or any neck/spine problem?	<input type="checkbox"/>	Have you ever had a menstrual period?	<input type="checkbox"/>
Do you regularly use a brace or assistive device?	<input type="checkbox"/>	Age when you had your first menstrual period?	<input type="checkbox"/>
Have you ever been diagnosed with asthma or other allergic disorders?	<input type="checkbox"/>	How many periods have you had in the last 12 months?	<input type="checkbox"/>
Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	Do you take a calcium supplement?	<input type="checkbox"/>
Is there anyone in your family who has asthma?	<input type="checkbox"/>	Explain "Yes" answers here:	<input type="checkbox"/>
Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>		<input type="checkbox"/>
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>		<input type="checkbox"/>
Have you had infectious mononucleosis (mono) within the last three months?	<input type="checkbox"/>		<input type="checkbox"/>
Have you ever had mono or any illness lasting more than two weeks?	<input type="checkbox"/>		<input type="checkbox"/>

Parent/Guardian Signature: _____

Athlete's Signature: _____

PART III - PHYSICAL EXAMINATION

NAME: _____

SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____ DOB: _____

* Tanner Stage or Maturation Index? (males only): _____ BP: _____

* Percent Body Fat: _____ * (Exercise) _____

* Audogram _____ * (Recovery) _____

* Vision: Corrected: (L) _____ (R) _____ (Both) _____

Uncorrected: (L) _____ (R) _____ (Both) _____

	N	Abnormal	N	Abnormal
Eyes				
Ears		Back		
Nose		Shoulders		
Throat		Arm/Elbow/wrist/hand		
Teeth		Knees/Hips		
Skin		Ankle/feet		
Lymphatic		Marian Screen		
Lungs		*Urine		
Heart		*Hemoglobin or HCT		
Peripheral pulses		and or Iron stores		
Abdomen		*Echocardiogram		
Genitalia/hernia (male only)		*Neuroptic Testing		
		*Pelvic Examination		

*WHEN MEDICALLY INDICATED (Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

*WITH SPECIAL INDICATIONS (These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

CLEARED WITHOUT RESTRICTIONS

Cleared AFTER further evaluation or treatment for:

Cleared for limited participation (check and explain "reason" for all that apply):

Cleared only for (specific sports):

NOT CLEARED FOR PARTICIPATION:

Reason(s):

Other Recommendations:

Recommend monitoring during early conditioning because of weight/fitness/other

Recommend restrictions or monitoring of weight loss or gain

Other: Reasons:

MD/DO, PA, NP, DE-SPC#, Signature: _____ Date Signed: _____

Date of Examination: _____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print): _____

Address: _____

City _____ State _____ Zip _____