TO BE COMPLETED BY PHYSICIAN'S OFFICE

Name_____ **Age**_____ **Date Of Birth**_____/_____/_____

Height_____Weight_____BP _____/_____ Pulse_____

Vision R 20/_____L 20/_____ Corrected: Y N Pupils_____

		Normal	Abnormal Findings	Initials
LIMITED	Cardiopulmonary			
	Pulses			
	Heart			
	Lungs			
	Tanner stage	1 2 3 4 5		
	Skin			
COMPLETE	Abdominal			
	Genitalia			
	Musculoskeletal			
	Neck			
	Shoulder			
	Elbow			
	Wrist			
	Hand			
	Back			
	Knee			
	Ankle			
	Foot			
	Other			

CLEARANCE

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for: [ ] Collision [ ] Contact

[ ] Non-contact ___ Strenuous ___ Moderately strenuous ___ Non strenuous

Name Of Physician/PA/Nurse Practitioner/Certified/Registered Chiropractor:

_____

ADDRESS_____**PHONE**_____

SIGNATURE OF MD/DO, PA, NA, DC-SPC# _____

DATE_____/_____/_____

TO BE COMPLETED BY STUDENT AND/OR PARENT

Date _____ Personal Physician_____

Name _____ Sex ___ Age ___ Date of birth ____/____/____

1. Have you ever been hospitalized? Yes [ ] No [ ]
   Have you ever had surgery? Yes [ ] No [ ]
2. Are you presently taking any medications or pills? Yes [ ] No [ ]
3. Do you have any allergies (medicine, bees or other stinging insects)? Yes [ ] No [ ]
4. Have you ever passed out during or after exercise? Yes [ ] No [ ]
   Have you ever been dizzy during or after exercise? Yes [ ] No [ ]
   Have you ever had chest pain during or after exercise? Yes [ ] No [ ]
   Do you tire more quickly than your friends during exercise? Yes [ ] No [ ]
   Have you ever had high blood pressure? Yes [ ] No [ ]
   Have you ever been told that you have a heart murmur? Yes [ ] No [ ]
   Have you ever had racing of your heart or skipped heartbeats? Yes [ ] No [ ]
   Has anyone in your family died of heart problems or a sudden death before age 50? Yes [ ] No [ ]
5. Do you have any skin problems (itching, rashes, and acne)? Yes [ ] No [ ]
6. Have you ever had a head injury? Yes [ ] No [ ]
   Have you ever been knocked out or unconscious? Yes [ ] No [ ]
   Have you ever had a seizure? Yes [ ] No [ ]
   Have you ever had a stinger, burner or pinched nerve? Yes [ ] No [ ]
7. Have you ever had heat or muscle cramps? Yes [ ] No [ ]
   Have you ever been dizzy or passed out in the heat? Yes [ ] No [ ]
8. Do you have trouble breathing or do you cough during or after activity? Yes [ ] No [ ]
9. Do you use any special equipment (pads, braces, mouth/eye guard, etc.)? Yes [ ] No [ ]
10. Have you had any problems with your eyes or vision? Yes [ ] No [ ]
    Do you wear glasses or contacts or protective eye wear? Yes [ ] No [ ]
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated or other injuries of any bones or joints? Yes [ ] No [ ]
    [ ] Head [ ] Shoulder [ ] Thigh [ ] Neck [ ] Elbow [ ] Knee [ ] Chest
    [ ] Forearm [ ] Shin/calf [ ] Back [ ] Wrist [ ] Ankle [ ] Hip [ ] Hand [ ] Foot
12. Have you had any other medical problems (mononucleosis, diabetes, etc.)? Yes [ ] No [ ]
13. Have you had a medical problem or injury since your last evaluation? Yes [ ] No [ ]
14. When was your last tetanus shot?_____
    When was your last measles immunization?_____
15. When was your first menstrual period?_____
    When was your last menstrual period?_____
    What was the longest time between your periods last year?_____

Explain "yes" answers:

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Date _____/_____/_____

Signature of athlete_____

Signature of parent/guardian_____