

**TO BE COMPLETED BY PHYSICIAN'S OFFICE**

**TO BE COMPLETED BY STUDENT AND/OR PARENT**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date \_\_\_\_\_ Personal Physician \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>C O M P L E T E</b>	<b>L I M I T E D</b>	Height _____ Weight _____ BP ____/____/____ Pulse _____			
		Vision R 20/____ L 20/____ Corrected: Y N Pupils _____			
			Normal	Abnormal Findings	Initials
		Cardiopulmonary			
		Pulses			
		Heart			
		Lungs			
		Tanner stage	1	2	3 4 5
		Skin			
		Abdominal			
	Genitalia				
	Musculoskeletal				
	Neck				
	Shoulder				
	Elbow				
	Wrist				
	Hand				
	Back				
Knee					
Ankle					
Foot					
Other					

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 \_\_\_\_\_

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_