

PART I - - MEDICAL HISTORY- Explain "Yes" answers below

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

GENERAL MEDICAL HISTORY		Yes	No	MEDICAL QUESTIONS (cont)		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?				30. Do you have any ononucleosis (mono) within the last month?		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever spent the night in the hospital?		<input type="checkbox"/>	<input type="checkbox"/>	31. Do you have any rashes, pressure sores, or other skin problems?		<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?		<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever had a herpes or MRSA skin infection?		<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	33. Are you currently taking any medication on daily basis? *		<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a head injury or concussion? If so, date of last injury:		<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart race skip beats during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	36. Do you have headaches with exercise?		<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/>							

		<input type="checkbox"/>	<input type="checkbox"/>	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an unexplained seizure?		<input type="checkbox"/>	<input type="checkbox"/>	40. Have you had any other blood disorders?		<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	41. Have you had any problems with your eyes or vision?		<input type="checkbox"/>	<input type="checkbox"/>
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		<input type="checkbox"/>	<input type="checkbox"/>	42. Do you wear glasses or contact lenses?		<input type="checkbox"/>	<input type="checkbox"/>
13. Does anyone in your family have a heart problem?		<input type="checkbox"/>	<input type="checkbox"/>	43. Do you wear protective eyewear, such as goggles or a face shield?		<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have a pacemaker or implanted defibrillator?		<input type="checkbox"/>	<input type="checkbox"/>	44. Do you use tobacco or alcohol?		<input type="checkbox"/>	<input type="checkbox"/>

				our last Tdap or Td (tetanus) immunization? (circle type) Date: _____			
18. Have you had any broken/fractured bones or dislocated joints?		<input type="checkbox"/>	<input type="checkbox"/>	49. Do you have an allergy to medicine, food or stinging insects?		<input type="checkbox"/>	<input type="checkbox"/>
19. 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"/>	<input type="checkbox"/>	FEMALES ONLY 50. Have you ever had a menstrual period?		<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?		<input type="checkbox"/>	<input type="checkbox"/>	51. Age when you had your first menstrual period? _____			
21. Have you ever had a stress fracture of a bone?		<input type="checkbox"/>	<input type="checkbox"/>	52. How many periods have you had in the last 12 months? _____			
22. Do you regularly use a brace or assistive device?		<input type="checkbox"/>	<input type="checkbox"/>	EXPLAIN "YES" ANSWERS BELOW: # _____ » _____ # _____ » _____ # _____ » _____ # _____ » _____			
23. Do you currently have a bone, muscle, or joint injury that bothers you?		<input type="checkbox"/>	<input type="checkbox"/>				
24. Do any of your joints become painful, swollen, feel warm, or look red?		<input type="checkbox"/>	<input type="checkbox"/>				
25. Do you have a history of juvenile arthritis or connective tissue		<input type="checkbox"/>	<input type="checkbox"/>				

* List medications and nutritional supplements you are currently taking here:

PART II – PHYSICAL EXAMINATION

NAME _____ Date of Birth _____ S S R U W _____

Date of EXAMINATION:				
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
BP /	Resting Pulse	Vision R 20/	L 20/	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

Medical Practitioner to School Staff (please indicate any instructions or recommendations here)

Emergency medications required on-site Inhaler Epinephrine Glucagon Other: _____

Comments: _____

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

CLEARED WITHOUT RESTRICTIONS

CLEARED WITH FOLLOWING NOTATION: _____

Cleared AFTER documented further evaluation or treatment for: _____

Cleared for limited participation (check and explain "reason" for all that apply) *limited Until Date" when appropriate*

Not cleared for (specific sports) _____ Until Date: _____

Reason(s): _____

NOT CLEARED FOR PARTICIPATION Reason _____

By this signature, I attest that I have examined the above st