SCHOOL: ______________________________

HISTORY **(to be completed by student and parent prior to examination by Physician)** **Date:** ____________

Name: ______________________ Phone: (____) ____________

Address: ______________________ City: ______________________ Zip: ____________

Sex: ______ Age: ______ Date of Birth: ______________________ Grade: ______

Personal Physician: ______________________ Phone: (____) ____________

Previous school attended and dates: ______________________

Explain "Yes" answers below:

1. Have you ever been hospitalized? .... Yes___ No___
   Have you ever had surgery? .... Yes___ No___
   Are you presently under a doctor's care? .... 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___
   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___
   Has anyone in your family had Marfan's syndrome? .... Yes___ No___
5. Do you have any skin problems (itching, rashes, 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 or epilepsy? .... Yes___ No___
   Have you ever had a stinger, burner or pinched nerve? .... Yes___ No___
7. Have you ever had heat cramps, heat illness or muscle cramps? .... 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, neck rolls, eye guards, 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. Are you missing an eye, kidney or testicle? .... Yes___ No___
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? .... Yes___ No___

☐ Head	☐ Shoulder	☐ Thigh	☐ Neck	☐ Elbow	☐ Knee	☐ Foot
☐ Forearm	☐ Shin/Calf	☐ Back	☐ Wrist	☐ Ankle	☐ Hip	☐ Hand

13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? .... Yes___ No___
14. **Have you had a medical problem or injury since your last evaluation?** .... Yes___ No___
15. When was your last tetanus shot? ______________________
16. 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. **(BOTH SIGNATURES ARE REQUIRED)**

- Signature of athlete: ______________________ Date: ____________
- Signature of parent/guardian: ______________________ Date: ____________

PHYSICAL EXAMINATION (to be completed by Physician) **Date:** ____________

Name: ______________________ Age: ______ Date of Birth: ____________

Height: ________ Weight: ________ BP: ______/______ Pulse: ________		
Vision: R 20/______ L 20/______ Corrected: Y N Pupils (Circle) Equal/Unequal R>L L>R		
	Circle (if option given)	**Specific Findings**
Marfan's syndrome stigmata	No Yes	
Heart		
Rhythm	Regular Irregular	
Murmur (supine)	No Yes	
Murmur (standing)	No Yes	
	Normal ❑	**Specific Findings**
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
Musculoskeletal:		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Clearance:

A. Cleared
B. Cleared after completing evaluation/rehabilitation for: ______________________
C. Not cleared

Due to: ______________________

Recommendation: ______________________

____

____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, **except those marked below:**

Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling

Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball

Name of Physician: ______________________ Date: ____________

Address: ______________________ Phone: (______) ____________

Signature of Physician: ______________________