PART I - - MEDICAL HISTORY- Expla in "Yes" answersbelow

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 don'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?					
			ononucleois (mono) within the last month?	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐	31. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
4. Have you ever had surgery?	☐	☐	32. Have you ever had a herpes or MRSA skin infection?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	33. Are you currently taking any medication on daily basis?	☐*	☐
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐	34. Have you ever had a head injury or concussion? If so, date of last injury:	☐	☐
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐	36. Do you have headaches with exercise?	☐	☐

8. Has a doctor ever told you that you have (check all that apply):
☐ High Blood Pressure ☐ A heart murmur
☐ High cholesterol ☐ A heart infection
☐

	☐	☐	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
11. Have you ever had an unexplained seizure?	☐	☐	40. Have you had any other blood disorders?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	41. Have you had any problems with your eyes or vision?	☐	☐
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)?	☐	☐	42. Do you wear glasses or contact lenses?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐	43. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
14. Does anyone in your family have a pacemaker or implanted defibrillator?	☐	☐	44. Do you the date of ld12.8700286.96 re S BT 0.0026 Tc -56100286.96 re S BT 0.		

			our last Tdap or Td(tetanus) immunization? (circle type) Date: ____________		
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐	49. Do you have an allergy to medicine, food or stinging insects?	☐	☐
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?	☐	☐	FEMALES ONLY 50. Have you ever had a menstrual period?	☐	☐
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?	☐	☐	51. Age when you had your first menstrual period? _______		
21. Have you ever had a stress fracture of a bone?	☐	☐	52. How many periods have you had in the last 12 months?___________		
22. Do you regularly use a brace or assistive device?	☐	☐			
23. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐			
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐			

25. Do you have a history of juvenile arthritis or connective tissue

EXPLAIN "YES" ANSWERS BELOW:

#____ » ____

#____ » ____

#____ » ____

#____ » ____

#____ » ____

* 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	☐ Male ☐ Female		
BP /	Resting Pulse	Vision R 20/	L 20/	Corrected ☐ Yes ☐ No

MEDIC AL	NORM AL	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