



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

**HISTORY**

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

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

Explain "Yes" answers below:

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, 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, neck rolls, mouth guard, 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 [ ] Foot  
[ ] Forearm [ ] Shin/calf [ ] Back [ ] Wrist [ ] Ankle [ ] Hip [ ] Hand
12. Have you had any other medical problems (infectious 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 \_\_\_\_\_

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

**PHYSICAL EXAMINATION**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

<b>C O M P L E T E</b>	<b>Height</b> _____ <b>Weight</b> _____ <b>BP</b> _____ / _____ <b>Pulse</b> _____ <b>G</b>
	<b>Vision R 20/</b> _____ <b>L 20/</b> _____ <b>Corrected:</b> <b>Y</b> <b>N</b> <b>Pupils</b> _____ <b>G</b>

**CLEARANCE**

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- C. Not cleared for: [ ] Collision  
[ ] Contact  
[ ] Non-contact \_\_\_ Strenuous \_\_\_ Moderately strenuous \_\_\_ Non strenuous

RECOMMENDATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR:

\_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

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

DATE: \_\_\_\_\_