PART II - PHYSICAL EXAMINATION

(Physical examination is required each school year after May 1 of the preceding school year and is good through June 30 of the current school year)**

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX:_____ AGE:_____ DOB: _____

*Tanner Stage or Maturation Index: (Males only):_____ BP::_____

Pulse: *(rest) _____

*Percent Body Fat:_____ *(Exercise) _____

*(Recovery) _____

*Audiogram: _____ *FEV or Peak Flow (rest) _____

*(Exercise) _____

*Vision: Corrected (L)_____ (R)_____ (Both)_____ *(Recovery) _____

Uncorrected (L)____(R)_____ (Both)_____

	N	ABNORMAL		N	ABNORMAL
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment base on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPEICAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation.)

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

☐ **CLEARED WITHOUT RESTRICTIONS**

☐ Cleared **AFTER** further evaluation or treament for: _____

_____

☐ Cleared for **LIMITED PARTICIPATION** (check and explain "reason" for all that apply):

- ☐ Not cleared for (specific sports)
- ☐ Cleared only for (specific sports)

Reason(s): _____

☐ **NOT CLEARED FOR PARTICIPATION:**

Reason(s): _____

☐ **Other Recommendations:**

- ☐ Recommend close monitoring during early conditioning because of weight/fitness/other
- ☐ Recommend restrictions or monitoring of weight loss or gain
- ☐ Other: _____

Reason(s): _____

Physician Signature: _____ M.D. Date of Examination**: _____

Date Signed: _____

Examiner's Name and degree (print): _____ Phone Number: _____

Address:_____City: _____State:_____ Zip:_____

PART I - MEDICAL HISTORY

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

MEDICAL HISTORY OF STUDENT & FAMILY	Yes	No	MEDICAL HISTORY OF STUDENT & FAMILY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	31. Have you had mono or any illness lasting more than two weeks?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	32. Do you have any rashes, pressure sores or other skin problems?	☐	☐
3. Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	☐	☐	33. Have you ever had herpes skin infection?	☐	☐
4. Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	34. Have you ever had a head injury or concussion?	☐	☐
5. Do you have prescriptions for use of epinephrine, adrenalin, inhaler or other allergy medications?	☐	☐	35. Date of last head injury or concussion: Date _____		
6. Have you ever passed out or nearly passed out during or after exercise?	☐	☐	36. Have you ever been hit in the head and been confused or lost yourmemory?	☐	☐
7. Have you ever passed out or nearly passed out at any other time?	☐	☐	37. Have you ever been knocked unconscious?	☐	☐
8. Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐	38. Have you ever had a seizure?	☐	☐
9. Have you ever had to stop running after 1/4 to 1/2 mile for chest pain or shortness of breath?	☐	☐	39. Do you have headaches with exercise?	☐	☐
10. Does your heart race or skip beats during exercise?	☐	☐	40. Have yyou ever had a numbness, tingling or weakness in your arms or legs after being hit or falling?	☐	☐
11. Has a doctor ever told you that you have (check all that apply): __ High Blood Pressure ___ A heart murmur ___High Cholesterol ___A heart Infection			41. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
12. Has a doctor ever ordered a test for your heart?	☐	☐	42. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
13. Has anyone in your family died suddenly for no apparent reason?	☐	☐	43. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
14. Does anyone in your family have a heart problem?	☐	☐	44. Have you had any other blood disorders or anemia?	☐	☐
15. Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death)	☐	☐	45. Have you had any problems with your eyes or vision?	☐	☐
16. Does anyone in your family have Marfan syndrome?	☐	☐	46. do you wear glasses or contact lenses?	☐	☐
17. Have you ever spent the night in a hospital?	☐	☐	47. do you wear protective eyewear, such as goggles or a face shield?	☐	☐
18. Have you ever had surgery?	☐	☐	48. Are you happy with your weight?	☐	☐
19. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐	49. Are you trying to gain or lose weight?	☐	☐
20. Have you had any broken or fractured bones or dislocated joints?	☐	☐	50. do you limit or carefully control what you eat?	☐	☐
21. 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?	☐	☐	51. Has anyone recommended you change your weight or eating habits?	☐	☐
22. Have you ever had a stress fracture?	☐	☐	52. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
23. Have you ever had an x-ray of your neck for atlanto-axial instability?	☐	☐	53. What is the date of your last tetanus immunization? Date: _____		
24. Do you regularly use a brace or assistive device?	☐	☐	**FEMALES ONLY** 54. Have you ever had a menstrual period?	☐	☐
25. Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐	55. Age when you had your first menstrual period? _____		
26. Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐	56. How many periods have you had in the last 12 months? _____		
27. Is there anyone in your family who has asthma?	☐	☐	57. Do you take calcium supplement?	☐	☐
28. Have you ever used an inhaler or taken asthma medicine?	☐	☐	**Explain "Yes" answers here:**		
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐			
30. Have you had infectious mononucleosis (mono) within the last three months?	☐	☐			

Parent/Guardian Signature:_____ Athlete's Signature: _____