

### PART III – 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: _____		
*Percent Body Fat: _____		Pulse: *(rest) _____		
*Audiogram: _____		*(Exercise) _____		
*Vision: Corrected (L) _____ (R) _____ (Both) _____		*(Recovery) _____		
Uncorrected (L) _____ (R) _____ (Both) _____		*FEV or Peak Flow (rest) _____		
		*(Exercise) _____		
		*(Recovery) _____		

	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				^Neuropsych Testing
Genitalia/hernia(male only)				^Pelvic Examination

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

**\*WITH SPECIAL 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 decision.)

**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 treatment 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: \_\_\_\_\_ +(MD, DO, LNP, PA)

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## PART II – 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?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had mono or any illness lasting more than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have prescriptions for use of epinephrine, adrenalin, inhaler or other allergy medications?	<input type="checkbox"/>	<input type="checkbox"/>	35. Date of last head injury or concussion: Date: _____		
6. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever passed out or nearly passed out at any other time?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had discomfort, pain or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	40. Have you ever had a numbness, tingling or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
11. 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			41. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever ordered a test for your heart?	<input type="checkbox"/>	<input type="checkbox"/>	42. When exercising in heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family died suddenly for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	43. 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"/>
14. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	44. Have you had any other blood disorders or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death)	<input type="checkbox"/>	<input type="checkbox"/>	45. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	47. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	48. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	49. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	50. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	51. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	52. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
23. 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"/>	53. What is the date of your last Tetanus immunization? Date: _____		
24. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALES ONLY</b>		
25. Have you ever been diagnosed with asthma or other allergic disorders?	<input type="checkbox"/>	<input type="checkbox"/>	54. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	55. Age when you had your first menstrual period? _____	<input type="checkbox"/>	<input type="checkbox"/>
27. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>	56. How many periods have you had in the last 12 months? _____	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>	57. Do you take a calcium supplement?	<input type="checkbox"/>	<input type="checkbox"/>
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b>		
30. Have you had infectious mononucleosis (mono) within the last three months?	<input type="checkbox"/>	<input type="checkbox"/>			

Parent/Guardian Signature: \_\_\_\_\_ Athlete's Signature: \_\_\_\_\_