

**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.

NO	YES	NO	YES	NO	YES	NO
1.	<input type="checkbox"/>	<input type="checkbox"/>	32.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	33.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	34.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	35.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	36.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	37.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	38.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	39.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	40.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	41.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	<input type="checkbox"/>	<input type="checkbox"/>	42.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	<input type="checkbox"/>	<input type="checkbox"/>	43.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	<input type="checkbox"/>	<input type="checkbox"/>	44.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	<input type="checkbox"/>	<input type="checkbox"/>	45.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	<input type="checkbox"/>	<input type="checkbox"/>	46.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	<input type="checkbox"/>	<input type="checkbox"/>	47.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	<input type="checkbox"/>	<input type="checkbox"/>	48.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	<input type="checkbox"/>	<input type="checkbox"/>	49.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	<input type="checkbox"/>	<input type="checkbox"/>	50.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	<input type="checkbox"/>	<input type="checkbox"/>	51.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	<input type="checkbox"/>	<input type="checkbox"/>	52.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	<input type="checkbox"/>	<input type="checkbox"/>	53.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	<input type="checkbox"/>	<input type="checkbox"/>	54.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	<input type="checkbox"/>	<input type="checkbox"/>	55.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	<input type="checkbox"/>	<input type="checkbox"/>	56.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	<input type="checkbox"/>	<input type="checkbox"/>	57.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	<input type="checkbox"/>	<input type="checkbox"/>				
28.	<input type="checkbox"/>	<input type="checkbox"/>				
29.	<input type="checkbox"/>	<input type="checkbox"/>				
30.	<input type="checkbox"/>	<input type="checkbox"/>				
31.	<input type="checkbox"/>	<input type="checkbox"/>				

**PART III -- PHYSICAL EXAMINATION**

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

\*Trainer Stage or Maturation Index? (males only): \_\_\_\_\_

\*Percent Body Fat: \_\_\_\_\_

\*Audiogram \_\_\_\_\_

\* Vision: Corrected: (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_

Uncorrected: (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_

Pulse: \*(rest) \_\_\_\_\_

\*(Exercise) \_\_\_\_\_

\*(Recovery) \_\_\_\_\_

\*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	
Lungs			Marfan Screen	
Heart			*Urine	
Peripheral pulses			*Hemoglobin or HCT and or Iron stores	
Abdomen			^Echocardiogram	
Genitalia/hiemla (male only)			^Neurophysic Testing	
			^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): \_\_\_\_\_
- NOT CLEARED FOR PARTICIPATION:** \_\_\_\_\_
- Reason(s): \_\_\_\_\_
- Other Recommendations: \_\_\_\_\_
- Recommend monitoring during early conditioning because of weight/fitness/other \_\_\_\_\_
- Recommend restrictions or monitoring of weight loss or gain \_\_\_\_\_
- Other: Reason(s): \_\_\_\_\_

MD/DO, PA, NP, DE-SPC #, Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Date of Examination: \_\_\_\_\_

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print): \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_

Athlete's Signature: \_\_\_\_\_