Student Name: _____ DOB: _____ Grade: _____ ID: _____

Medical History Questionnaire

1. Have you ever been hospitalized overnight?	Yes	No
Have you ever had surgery?	Yes	No
2. Are you currently taking medication?	Yes	No
3. Do you have any allergies (medicines, pollen, bees)?	Yes	No
List allergies: _____		
4. Have you ever passed out during exercise? (Not from heat)	Yes	No
Have you ever been dizzy during exercise? (Not from heat)	Yes	No
Have you ever had chest pain?	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 you have a heart murmur?	Yes	No
Have you ever had racing of your heart or skipped beats?	Yes	No
Has anyone in your family died of heart problems or a sudden death before the age of 40?	Yes	No
Does anyone in your family have Marfan's Syndrome?	Yes	No
5. Do you have any skin problems (itching, rashes, breaking out)?	Yes	No
6. Have you ever had a head injury?	Yes	No
Have you ever been knocked out?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had pain from neck into arm?	Yes	No
7. Have you ever had heat cramps?	Yes	No
Have you ever been dizzy or passed out in the heat?	Yes	No
8. Do you use special pads or braces?	Yes	No

9. Have you ever injured (broken/fractured, sprained, or dislocated):
___hand/fingers ___shoulder ___hip ___shin/calf ___wrist/forearm
___neck ___thigh ___elbow ___chest/ribs ___knee
___ankle ___upper arm ___back ___stress fracture

10. Have you ever had?
___mononucleosis ___diabetes ___measles ___hernia
___sickle cell trait/disease ___headaches-frequent ___ulcers ___hepatitis
___asthma ___eye/ear injuries ___tuberculosis

11. When was your last tetanus shot? _____

12. About your weight: do you think you are:
___just right ___too heavy/fat ___too light/thin

13. For Females:
When was your 1st period and how old were you? _____
When was your last period? _____

14. Please feel free to ask the doctor to address any questions/concerns that you have _____
_____

Explain all "Yes" responses to Questions 1-8:
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature: _____ Parent Signature: _____ Date: _____

Student Name: _____ DOB: _____ Grade: _____ ID: _____

Physical Examination (To be completed by medical personnel)

Height _____ Weight _____ BP ____/____ Pulse _____

Vision (optional) Left eye 20/_____ Right eye 20/____

1.	Skin		**10.**	Genitalia (optional)	
2.	Head		**11.**	Extremities	
3.	Eyes (PERL, EOMI, Fundi)		**12.**	Neurological	
4.	Ears, nose, throat		**13.**	Orthopedic	
5.	Neck			Cervical spine/back	
6.	Lymphatic			Arms/elbows/wrist/hands	
7.	Respiratory			Hips	
8.	Cardiovascular			Knees	
	Heart (murmurs?)			Ankles / feet	
9.	Abdomen		**14.**	Developmental	
				Tanner staging 1-5 (opt)	

√ = WNL X = omitted + = see "Notes" below

Please check one:

_____Full, unrestricted clearance

_____Not cleared. Needs clearance by specialist: (Please note below)
___Orthopedist ___Cardiologist ___Other

Notes: _____

_____

If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete. In the event that the student-athlete should be afflicted with a condition after initial clearance, the individual may require additional clearance paperwork be turned into the athletic trainer.

Screenings may only be performed by licensed **MD, DO, PAC, and NP**
Physicals must be completed after 6/1/24

Athletic Screening performed by:

Print _____ MD / DO / PAC / NP (circle one)

Signature _____ Date _____

Place Practitioner Office Stamp Here (Required)