



PHYSICAL EXAMINATION CLEARANCE FORM

This form must be on file in the school before practicing with any athletic team

Student Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Address: _____

Home Telephone: _____ - _____ - _____

School: _____ Grade: _____ Sports: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check One Box)

(1) Participate in all school interscholastic activities without restrictions.

(2) Not cleared for: All Sports Specific Sports _____

Cross out specific sports below not cleared for participation.

Sport classification based on contact:

Collision Contact Sports		Limited Contact Sports			Non-contact Sports	
Basketball	Ice Hockey	Baseball	Alpine Skiing	Track Field Events	Bowling	Track Running
Boys Lacrosse	Soccer	Competitive Cheer	Girls Softball	High Jump	Cross Country	Track Field Events
Diving	Wrestling	Girls Lacrosse		Pole Vault	Golf	Discus
Football		Girls Gymnastics		Girls Volleyball	Swimming	Shot Put
					Tennis	

Sport classification based on intensity and strenuousness:

High Intensity High-to-Moderate Dynamic High-to-Moderate Static		High Intensity High-to-Moderate Dynamic Low Static		High Intensity Low Dynamic High-to-Moderate Static	Low Intensity Low Dynamic Low Static
Alpine Skiing	Track Events - Distance	Baseball	Swimming	Girls Competitive	Bowling
Cross Country	Track Events - Sprint	Lacrosse (Boys and Girls)	Tennis	Cheer	Golf
Football	Wrestling	Soccer	Girls Volleyball	Diving	
Ice Hockey		Girls Softball		Field Events	
				Girls Gymnastics	

(3) Requires further evaluation before a final recommendation can be made.

Additional recommendations for the school or parents: _____

I have examined the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Examiner Signature: _____ Date of Exam: _____

Print Examiner Name: _____

Address: _____

Office Telephone: _____ - _____ - _____

COPY BOTH SIDES OF THIS SHEET FOR THE STUDENT TO RETURN TO THE SCHOOL AND KEEP THE ENTIRE FORM IN THE STUDENTS MEDICAL RECORD

----- < DETACH HERE IF NEEDED TO ACCOMPANY STUDENT ATHLETE > -----

EMERGENCY INFORMATION FOR: _____ Grade: _____

Allergies – Drug Reactions – Current Medications: _____

Other Special Medical Information: _____

Emergency Contact: _____ Relationship: _____

Telephone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (C) _____ - _____ - _____

Personal Physician _____ Office Telephone _____ - _____ - _____



INFORMATION & CONSENT FORM

To be completed by parent/guardian or 18 year old or older student-athlete; please take time to complete the form to ensure the good health and safety of the student-athlete
 Must be signed in **four (4)** places by parent/guardian or 18 year old or older student-athlete (Below and on page 3)
 The exam date must be performed **on or after April 15th** to be valid for the following school year
 The first two pages, Clearance Form and Information & Consent Form, must be kept on file with school athletic department

Student Name: _____		
Last	First	Middle Initial
Sex: _____	Grade: _____	Age: _____ Date of Birth: _____
School: _____		Sport(s): _____
Student's Address: _____		
Street	City	Zip
Father's/Guardian Name: _____		
Phone (home): _____	(work): _____	(cell): _____
Mother's/Guardian Name: _____		
Phone (home): _____	(work): _____	(cell): _____

SIGNATURES CONSENTING TO CONDITIONS OF PARTICIPATION

STUDENT DISCLOSURE AND ACCEPTANCE OF CONDITIONS TO PARTICIPATE: This application to participate in athletics is voluntary on my part and the information submitted is truthful to the best of my knowledge.

I have never received money or negotiable certificate for merchandise in any amount, nor any emblematic award or merchandise worth more than twenty-five dollars (\$25.00) for participating in athletic events, nor have I ever under an assumed name. After I have represented my school in any sport, I will not compete in any outside athletic contest in this sport until after my school season has been completed.

I understand that I am expected to adhere firmly to all established athletic policies of my school district and the Michigan High School Athletic Association, such as those previously mentioned above as examples but which do not present all the policies to which I am subject.

Signature of STUDENT: _____ **Date:** _____



INSURANCE STATEMENT: Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: Yes No

If yes, Family Insurance Co: _____ Contract # _____

CONSENT TO DISCLOSURE: I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics; and I understand the possibility that serious injury may result from participating in athletic activities. He/She has my permission to accompany the team as a member on its out-of-town trips.

I further understand that my son or daughter will be expected to adhere firmly to all established athletic policies of the school district and the Michigan High School Athletic Association.

Signature of PARENT OR GUARDIAN OR 18 YEAR-OLD **Date**



MEDICAL TREATMENT CONSENT: I, _____, an 18 year-old, or the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

Signature of PARENT OR GUARDIAN OR 18 YEAR-OLD **Date**



PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, 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 <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
 Pending further evaluation
 For any sports
 For certain sports _____
Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. 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 (and parents/guardians).

Name of physician (print/type) _____ Date _____
Address _____ Phone _____
Signature of physician _____, MD or DO