MEDICAL CLEARANCE FOR SPORT TRYOUT

<u>Directions to the Student-Athlete</u>:
1. Please complete and sign Page 1.
2. Present both pages to your physician.
3. Return the completed and signed forms to the training staff.
4. If you are trying out for crew, you must present evidence of swimming certification to the training staff.

<u>Directions to the Examining Physician</u>:
1. Please review and sign Page 1, clarifying any 'Yes' answers.
2. Please complete and sign the exam form on Page 2.
3. Please indicate your recommendations.
4. Please return the completed form to the student

Name: ____	Sex: _________	Age: _________	DOB: ___________________________
Address: ____		Phone: _____________________________	
SPORT: ____		DATE OF EXAM: _________________________________	

Please explain any 'Yes' answers below

		Yes	No
1.	Have you had a medical illness or injury since your last check-up or sports physical?	___	___
	Do you have an ongoing or chronic illness?	___	___
2.	Have you ever had surgery?	___	___
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	___	___
	Are you allergic to any medications?	___	___
4.	Have you ever had a head injury or concussion?	___	___
	Have you ever been knocked out, become unconscious, or lost your memory?	___	___
	Have you ever had a seizure?	___	___
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	___	___
	Have you ever had a stinger, burner or pinched nerve?	___	___
5.	Have you ever had a sprain, strain, or swelling after injury?	___	___
	Have you ever fractured any bones or dislocated any joints?	___	___
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
	If yes, check applicable box and explain below.	___	___

		Yes	No
6.	Have you ever passed out during or after exercise?	___	___
	Have you have been dizzy during or after exercise?	___	___
	Have you ever had chest pain during or after exercise?	___	___
	Do you get tired more quickly than your friends do during exercise?	___	___
	Have you ever had racing of your heart or skipped heartbeats?		
	Have you had high blood pressure or high cholesterol?	___	___
	Have you ever been told you have a heart murmur?	___	___
	Has any family member or relative died of heart problems or of sudden death before the age of 50?	___	___
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
	Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
7.	Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
	Do you have asthma?	___	___
8.	Have you ever become ill from exercising in the heat?	___	___
9.	Are you missing one of the following: kidney, eye, testicle (or an undescended testicle)?	___	___

___Head	___Elbow	___Hip
___Neck	___Forearm	___Thigh
___Back	___Wrist	___Knee
___Chest	___Hand	___Shin/Calf
___Shoulder	___Finger	___Ankle
___Upper Arm		___Foot

Explain any "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 student: ____ Date: _____________________________________

I have reviewed the questions with the student athlete.

Signature of physician: ____ Date: _____________________________________

Name: ____

Height: ____________________ Weight: ____________________ Pulse: ____________________ BP: _____________ / ______________

Vision R 20 / : ___________ L 20 / _______________ Corrected: Y N

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

ASSESSMENT:

RECOMMENDATIONS: (please check one)

☐ I find nothing in the history and physical examination to preclude participation. I recommend full participation.
☐ One or more issues have been identified that need to be addressed prior to participation.
☐ I do not recommend participation for this individual. Reason: ____

Name of physician (print): ____

Signature of physician: ____ Date: _____________________________________

Physician Address: ____ Phone: ______________________

STAFF ONLY

CLEARANCE STATUS	
☐ CLEARED DATE CLEARED: __________________________	☐ NOT CLEARED REASON: ________________________________

Name of Team Physician: _______________________________________ Signature: ____ Date: ______________