2026 Charlie Wedemeyer High School All Star Football Game

Athletic Pre-Participation Physical Examination

IMPORTANT NOTICE: THIS FORM REQUIRES YOUR DOCTOR'S SIGNATURE.

NOTE: We will accept a doctor signed School Physical Exam ONLY if dated AFTER FEBRUARY 1, 2025

PART 1: History (**to be completed by student and parent or guardian**)

Student's Name:_____ Age:_____ Birthdate: _____

Address: _____ City: _____ Zip: _____

High School Attended: _____ _____

Emergency Contact Name: _____ Relationship: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Doctor's Name: _____ Phone: _____

Health Insurance Carrier: _____ Policy No.: _____

Date of last physical examination: _____ _____

HEALTH HISTORY (**must be completed prior to participation**): **Has this student had any history of:**

YES	NO	DESCRIPTION		YES	NO	DESCRIPTION
		Hospitalization?				Catching or clicking of a joint?
		Surgery other than removal of tonsils?				Broken bones/fractures?
		Missing organs (eye, kidney, testicle)?				Stingers/burners or pinched nerves?
		Allergies (medicines, insects, food)?				Ulcers or hernias?
		Chest pain or severe shortness of breath?				Skin problems?
		Problems w/blood pressure or heart (heart murmur)?				Head injury?
		Dizziness or fainting with exercise?				Neck or back injury?
		Severe or frequent headaches?				Chest injury?
		Concussion or loss of consciousness?				Shoulder/Upper Arm injury?
		Heat exhaustion, heat stroke or other problems with heat?				Elbow/Forearm injury?
		Mononucleosis, hepatitis, hemophilia?				Hand, wrist or finger injury?
		Diabetes?				Hip injury?
		Seizures/convulsions?				Thigh injury?
		Dislocation of a joint?				Knee injury?
		Ankle/foot injury?				Shin/calf injury?
		Has any family member or relative died of heart problems or of sudden death before age 50?				**Date of last Tetanus shot:**

Explain any "**Yes**" answers to the Health History questions and list any pertinent information:

PART 2:

I have reviewed and agree with the information presented on this form. I also understand that this questionnaire is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal physician. I know of no reason why the above-named student should not participate and represent his or her school in supervised athletic activities.

PRINT PARENT/GUARDIAN's NAME: _____

Parent/Guardian Signature:_____ Date:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Personal Physician's Statement: **(This area for Doctor's/Clinic's Stamp)**

The above-named student is cleared for sports activity with no restrictions.

Doctor's Signature:_____

Date: _____

NOTE: ***Above statement may also be provided on Doctor's personal letterhead.***