

(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: _____

Name: _____
 Home Address: _____
 Phone: _____
 Date of Birth: _____
 Age: _____
 Sex Assigned at Birth: _____
 Grade: _____
 School: _____
 Sport(s): _____
 Personal Physician: _____
 Hospital Preference: _____

In case of emergency contact:
 Name: _____
 Relationship: _____
 Phone (Home): _____
 Phone (Work): _____
 Phone (Cell): _____
 Name: _____
 Relationship: _____
 Phone (Home): _____
 Phone (Work): _____
 Phone (Cell): _____

Explain "Yes" answers on the following page.
 Circle questions you don't know the answers to.

	Yes	No
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2) List past and current medical conditions: _____	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods or stinging insects? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (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"/>	<input type="checkbox"/>
7) Have you ever had surgery? (Please list): _____	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 10)	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm		
<input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh		
<input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes		

	Yes	No
11) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
13) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
14) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
15) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
16) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
19) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
20) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
21) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
25) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
26) Have you or someone in your family tested positive for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
27) Have you been hospitalized or had long-term complication care due to COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
28) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
29) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
30) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Females Only

Explain "Yes" Answers Here

	Yes	No
33) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
34) How old were you when you had your first menstrual period?	_____	
35) How many periods have you had in the last year?	_____	

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Share About Your Child

	Yes	No
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Share Any Notes Related To The Above Section

Family History Questions: Please Share About Any Of The Following In Your Family

			Yes	No
1)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)		<input type="checkbox"/>	<input type="checkbox"/>
2)	Are there any family members who died suddenly of "heart problems" before age 50?		<input type="checkbox"/>	<input type="checkbox"/>
3)	Are there any family members who have unexplained fainting or seizures?		<input type="checkbox"/>	<input type="checkbox"/>
4)	Are there any relatives with certain conditions, such as:			
		Yes	No	
	Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	
	Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	
	Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	
	Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	
	Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	
	Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
	Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)		<input type="checkbox"/>	<input type="checkbox"/>
	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)		<input type="checkbox"/>	<input type="checkbox"/>
	Marfan Syndrome (Aortic Rupture)		<input type="checkbox"/>	<input type="checkbox"/>
	Heart Attack, Age 50 or Younger		<input type="checkbox"/>	<input type="checkbox"/>
	Pacemaker or Implanted Defibrillator		<input type="checkbox"/>	<input type="checkbox"/>
	Deaf at Birth		<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

Additional History

		Yes	No
1)	Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?	<input type="checkbox"/>	<input type="checkbox"/>
2)	Do you drink alcohol or use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>
3)	Have you ever taken anabolic steroids or used any other performance-enhancing supplements?	<input type="checkbox"/>	<input type="checkbox"/>
4)	Have you ever taken any supplements to help you gain or lose weight, or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
5)	Do you always wear a seatbelt while in a vehicle?	<input type="checkbox"/>	<input type="checkbox"/>

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Student-Athlete

Signature of Parent/Guardian

Date

Name: _____ Date of Birth: _____
 Age: _____ Sex: _____
 Height: _____ Weight: _____ % Body Fat (optional): _____
 Pulse: _____ Blood Pressure (1st measure): ____ / ____ (2nd measure) ____ / ____ (3rd measure) ____ / ____
 Vision: R20/____ L20/____ Corrected: Y N Pupils: Equal Unequal

Medical	Normal	Abnormal
Appearance		
Eyes/Ears/Throat/Nose		
Hearing		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary&		
Skin		

Musculoskeletal	Normal	Abnormal
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

A complete PPE requires the information below completed as text or with the official stamp of the provider's office.

* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES AND RECOMMENDATIONS:

- Cleared without restriction for all sports
- Cleared with the following restrictions and/or recommendations: _____

- Not cleared for any sports [Reason(s)]: _____

Medical Professional has reviewed family history _____ (Initials) Exam Date: _____

Name of Medical Professional (Print/Type): _____

Address: _____

Phone: _____

Signature of Medical Professional: _____

Medical Credential (Circle): MD / DO / ND / NP / PA-C / CCSP