



Academic Year	Sport(s)	Exam Date
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**SECTION 1 · ATHLETE INFORMATION**

Full Legal Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Jersey/ID # \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School / Organization \_\_\_\_\_ Biological Sex  Male  Female  Other

**SECTION 2 · EMERGENCY CONTACT & INSURANCE**

Emergency Contact 1 — Name \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact 2 — Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Policy / Member ID # \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber Name \_\_\_\_\_

**SECTION 3 · MEDICAL HISTORY**

#	QUESTION	YES	NO
1.	Has the athlete ever been told they have a heart problem, murmur, or irregular heartbeat?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has the athlete fainted, felt dizzy, or had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the athlete ever had a seizure or been diagnosed with epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has the athlete been diagnosed with asthma or exercise-induced bronchospasm?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has the athlete ever been hospitalized overnight or had surgery (any reason)?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Has the athlete ever had a head injury, concussion, or been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has the athlete ever had a broken bone, stress fracture, or joint dislocation?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does the athlete have any known food, medication, or environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Is the athlete currently taking any prescription or over-the-counter medications?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has the athlete ever been restricted from sports participation for any medical reason?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Does the athlete have diabetes, sickle cell trait/disease, or any blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does the athlete have only one functioning kidney, eye, or testicle?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any family member (parent/sibling) died suddenly before age 50 of heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does the athlete have a history of depression, anxiety, or any mental health condition?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Has the athlete ever used performance-enhancing supplements or steroids?	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any question — explain fully (include dates, treatment, and current status):




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**Current Medications** name, dosage, frequency — attach additional sheet if needed

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**Known Allergies & Reactions** include epinephrine auto-injector use if applicable

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**SECTION 4 · PHYSICIAN PHYSICAL EXAMINATION**

*Completed by licensed provider only.*

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **BMI** \_\_\_\_\_ **BP** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Temp** \_\_\_\_\_  
**Vision R** \_\_\_\_\_ **Vision L** \_\_\_\_\_ **Corrected** \_\_\_\_\_ **Hearing R** \_\_\_\_\_ **Hearing L** \_\_\_\_\_

**Systems Review**

BODY SYSTEM	NORMAL	ABNORMAL	NOT EVAL.	NOTES / FINDINGS
Cardiovascular / Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory / Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen / Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal — Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal — Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal — Spine & Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin / Dermatological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental / Oral (mouthguard fit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Additional Examination Findings / Referrals Needed**

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**SECTION 5 · PHYSICIAN CLEARANCE DETERMINATION**

**Clearance Status** (check one)

- CLEARED** — no restrictions; full sport participation approved
- CLEARED WITH CONDITIONS** — restricted or modified participation (see notes)
- NOT CLEARED** — athlete may not participate pending further evaluation or treatment



**Conditions / Restrictions / Follow-up Required**

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<b>Physician / Provider Printed Name</b>	<b>Signature</b>
<b>Clinic / Practice</b>	<b>Date of Examination</b>
<b>License #</b>	<b>Phone</b>

**SECTION 6 · ATHLETE & PARENT/GUARDIAN CONSENT**

I/We, the undersigned, certify that all medical history information provided in this form is accurate and complete to the best of my/our knowledge. I/We authorize the examining physician to release relevant medical information to OA Guardians coaching staff and athletic personnel as necessary to ensure the athlete's safe participation. I/We acknowledge that participation in football carries inherent risks of injury, and I/We grant permission for the athlete to participate under the conditions stated above. I/We agree to immediately notify OA Guardians staff of any changes in the athlete's health status that may affect participation. I/We have read and understand the OA Guardians Player and Parent Handbook, including the Concussion Policy.

<b>Athlete Signature</b>	<b>Parent/Guardian Signature</b>
<b>Athlete Printed Name</b>	<b>Parent/Guardian Printed Name</b>
<b>Date</b>	<b>Date</b>
<b>Relationship to Athlete</b>	<b>Parent/Guardian Phone</b>

**SECTION 7 · ADDITIONAL HEALTH INFORMATION (OPTIONAL)**

<b>Primary Care Physician</b>	<b>Phone</b>
<b>Preferred Hospital / ER</b>	<b>Pharmacy</b>

**Additional Health Notes**

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**RECORD RETENTION:** This form is valid for the current season only. Retain in the athlete medical file for a minimum of seven (7) years.