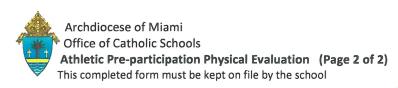


Signature of Parent/Guardian_

Pa	art 1. Student Information (to be completed by the pare	ent).													
St	udent Name:				Sex:	Age	Date of Birth/		/						
School: Grade in School Sport(s) expected to play															
Н	Home Address: Home Phone ()														
Na	Name of Parent/Guardian:														
Pe	Person to Contact in Case of Emergency:														
Re	elationship to Student:	Home Pho	one: ()		Work	Phone: ()								
Personal/Family Physician:															
	Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer														
Yes No Yes No															
1.	Has child had a medical illness or injury since the last check up or sports physical?			26.	Has child ever be	come ill from exercisi	ng in the heat?								
2,	Does child have an ongoing chronic illness?			27.	. Does child cough, wheeze or have trouble breathing during or after activity?										
3.	Has child ever been hospitalized overnight?			28.	Does child have a	-	-								
4.	Has child ever had surgery?			29.	Does child have seasonal allergies that require medical treatment?										
5.	Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	-		30.	Does child have any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example,			***************************************							
6.	Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?			21	knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Has child had any problems with his/her eyes or vision?										
7.	Does child have any allergies (for example to pollen, medicine, food or stinging insects)?					lasses, contacts, or p									
8.	Has child ever had rash or hives develop during or after exercise?					d a sprain, strain, or s									
9.	Has child ever passed out during or after exercise?			34.	Has child broken or fractured any bones or dislocated any joints?										
10.	Has child ever been dizzy during or after exercise?			35.	Has child had any other problems with pain or swelling in muscles,										
11.	Has child ever had chest pain during or after exercise?				tendons, bones, or joints?										
12.	Does child get tired more quickly than friends during exercise?				If yes, check appropriate blank and explain below:										
13.	Has child ever had racing of the heart of skipped heartbeats?				Head	Elbow	Hip								
14.	Has child had high blood pressure or high cholesterol?				Neck	Forearm	Thigh								
15.	Has child ever been told he/she has a heart murmur?				Back	Wrist	Knee								
16.	Has any family member or relative died of heart problems or sudden death before age 50?				Chest	Finger	Ankle								
17.	Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?				Upper Arm	Foot									
18	Has a physician ever denied or restricted child's participation in sports			36.	36. Does child want to weigh more or less than child weighs now?37. Does child lose weight regularly to meet weight requirements for a sport?		han child weighs now?								
	for any heart problems?			37.			-								
19.	Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?			38.	Does child feel stressed out?			-							
20.	Has child ever had a head injury or concussion?			39.	Record the dates	of his/most recent Imi	nunizations (shots) for:								
21.	Has child ever been knocked out, become unconscious, or lost his/her memory?				Tetanus	Meas	es:								
22.	Has child ever had a seizure?				Hepatitus B	Chick	эпрох:								
23.	Does child have frequent or severe headaches?														
24.	Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?														
25.	Has child ever had a stinger, burner, or pinched nerve?														
хр	lain "Yes" answers here:														
hei	eby state, to the best of my knowledge, that my answers to the above q	uestions ar	re comple	ete and co	orrect.										

Date:_



Part 3. Physical Examination (to be completed by physician).												
Student Name: Date of Birth/												
Height: Weight: _	% Body Fat (optional):	Pulse:	_ Blood Pressure:/	(_/)						
Visual Acuity: Right 20/ Lef	t 20/ Corrected:	Yes No	Pupils: Equal	Unequal								
FINDINGS	NORMAL	ABNORM	AL FINDINGS		INITIALS*							
MEDICAL												
1. Appearance												
2. Eyes/Ears/Nose/Throat												
3. Lymph Nodes				~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~								
4. Heart		·										
5. Pulses												
6. Lungs					to shall have sales here and some some							
7. Abdomen												
8. Skin	AND THE OUT WITH MICH SHEET SAND THE SAND SAND SAND											
MUSCULOSKELETAL												
9. Neck												
10. Back						NAME AND ADD THE SPECIAL COST OFFICE AND ADDRESS AND A						
11. Shoulder/Arm						And also see you, updated yet with this time stateped yets table see see						
12. Elbow/Forearm												
13. Wrist/Hand					rection made about book basely page							
14. Hip/Thigh						NATIONAL SERVICE AND ADDRESS TO THE SERVICE AND ADDRESS AND ADDRES						
15. Knee	and the same and the same and an annual and					alle alle une une mar ann ann ann ann ann ann ann ann ann a						
16. Leg/Ankle												
17. Foot						siller final time that when time with main hand dide you time man may again ages						
* - Station-based examination only	,					With tend some wild share then then then delivate allow open upon alone data along upon						
ASSESSMENT OF EXAMINING F												
Cleared without limitation												
Not cleared for				Re	ason							
Cleared after completing ev	aluation/rehabilitation for:											
Referred to				For	T	arter que recordo este altre da está dife aler der anti dal talpado anti des ano elector per ese ano en						
				The state of the same was any data who will pape upon all the same attended that who will be stated the same and the same attended to t								
Recommendations:												
Name of Physician (print or type):_					Date:							
Address:												
Signature of Physician:						, MD, DO, DC, ARNP						
ASSESSMENT OF PHYSICIAN T												
hereby certify that the examinatio	n(s) for which referred wa	is/were performed	by myself or an indivi	dual under my direct supervisio	n with the following co	nclusion(s)						
Cleared without limitation												
Not cleared for												
Cleared after completing eva	aluation/rehabilitation for:					their state was also secreted and the time and the state state and the secretary was asserted that the state and their secretary was a secretary was a secretary with the secretary was a secr						
Referred to				For								
Recommendations:												
lame of Physician (print or type):_					Date:							
Address:												
Signature of Physician:	•											

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.