



# PHYSICAL EXAMINATION CLEARANCE FORM

This form must be on file in the school before practicing with any athletic team

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Sports: \_\_\_\_\_

I certify that the above student has been medically evaluated and is deemed to be physically fit to: (Check One Box)

(1) Participate in all school interscholastic activities without restrictions.

(2) Not cleared for:  All Sports  Specific Sports \_\_\_\_\_

Cross out specific sports below not cleared for participation.

### Sport classification based on contact:

Collision Contact Sports		Limited Contact Sports			Non-contact Sports	
Basketball	Ice Hockey	Baseball	Alpine Skiing	Track Field Events	Bowling	Track Running
Boys Lacrosse	Soccer	Competitive Cheer	Girls Softball	High Jump	Cross Country	Track Field Events
Diving	Wrestling	Girls Lacrosse		Pole Vault	Golf	Discus
Football		Girls Gymnastics		Girls Volleyball	Swimming	Shot Put
					Tennis	

### Sport classification based on intensity and strenuousness:

High Intensity High-to-Moderate Dynamic High-to-Moderate Static	High Intensity High-to-Moderate Dynamic Low Static	High Intensity Low Dynamic High-to-Moderate Static	Low Intensity Low Dynamic Low Static
Alpine Skiing Cross Country Football Ice Hockey	Track Events - Distance Track Events - Sprint Wrestling	Baseball Lacrosse (Boys and Girls) Soccer Girls Softball	Bowling Golf
		Swimming Tennis Girls Volleyball	Girls Competitive Cheer
			Diving Field Events Girls Gymnastics

(3) Requires further evaluation before a final recommendation can be made.

Additional recommendations for the school or parents: \_\_\_\_\_

*I have examined the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).*

Examiner Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Print Examiner Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**COPY BOTH SIDES OF THIS SHEET FOR THE STUDENT TO RETURN TO THE SCHOOL AND KEEP THE ENTIRE FORM IN THE STUDENTS MEDICAL RECORD**

----- < DETACH HERE IF NEEDED TO ACCOMPANY STUDENT ATHLETE > -----

**EMERGENCY INFORMATION FOR:** \_\_\_\_\_ Grade: \_\_\_\_\_

Allergies – Drug Reactions – Current Medications: \_\_\_\_\_

Other Special Medical Information: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (W) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (C) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Personal Physician \_\_\_\_\_ Office Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PREPARTICIPATION PHYSICAL EVALUATION**

**HISTORY FORM**

(This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

\_\_\_\_\_

Do you have any allergies? Yes  No  If yes, please identify specific allergy below.

- Medicines  Pollen  Food  Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, 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"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or herma in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you ever received tetanus-diphtheria-pertussis (Tdap) vaccine?		
52. Are you missing any recommended vaccines (such as Tdap, MCV4, HPV, Varicella, MMR, Flu, etc.)?		
53. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "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 athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

**PREPARTICIPATION PHYSICAL EVALUATION**  
**PHYSICAL EXAMINATION FORM**  
 (The provider should keep this form in the chart)

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**PHYSICIAN REMINDERS:**

1. Consider additional questions on more sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - During the past 30 days, did you use chewing tobacco, snuff or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seatbelt, use a helmet and use condoms?
2. Please review questions on cardiovascular symptoms and family history (questions 5-16) with parent and/or student athlete

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP	/ ( / )	Pulse	Vision R 20/ L 20/ Corrected Yes or No
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>• Pupils equal</li> <li>• Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>• Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>• Location of point of maximal impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>• Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin <ul style="list-style-type: none"> <li>• HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> <li>• Duck-walk, single leg hop</li> </ul>			

\* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup> Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup> Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

**Immunizations:**  
 Has the student-athlete received all ACIP-recommended vaccines?  Yes  No

Check the Michigan Care Improvement Registry (MCIR) for vaccination status: [www.mcir.org](http://www.mcir.org)



# INFORMATION & CONSENT FORM

To be completed by parent/guardian or 18 year old or older student-athlete; please take time to complete the form to ensure the good health and safety of the student-athlete  
 Must be signed in **four (4)** places by parent/guardian or 18 year old or older student-athlete (Below and on page 3)  
 The exam date must be performed **on or after April 15<sup>th</sup>** to be valid for the following school year  
 The first two pages, Clearance Form and Information & Consent Form, must be kept on file with school athletic department

Student Name: _____		
Last	First	Middle Initial
Sex: _____	Grade: _____	Age: _____
Date of Birth: _____		
School: _____		Sport(s): _____
Student's Address: _____		
Street		City
Father's/Guardian Name: _____		Zip
Phone (home): _____		(work): _____
		(cell): _____
Mother's/Guardian Name: _____		
Phone (home): _____		(work): _____
		(cell): _____

## SIGNATURES CONSENTING TO CONDITIONS OF PARTICIPATION

**STUDENT DISCLOSURE AND ACCEPTANCE OF CONDITIONS TO PARTICIPATE:** This application to participate in athletics is voluntary on my part and the information submitted is truthful to the best of my knowledge.

I have never received money or negotiable certificate for merchandise in any amount, nor any emblematic award or merchandise worth more than twenty-five dollars (\$25.00) for participating in athletic events, nor have I ever under an assumed name. After I have represented my school in any sport, I will not compete in any outside athletic contest in this sport until after my school season has been completed.

I understand that I am expected to adhere firmly to all established athletic policies of my school district and the Michigan High School Athletic Association, such as those previously mentioned above as examples but which do not present all the policies to which I am subject.

Signature of STUDENT: \_\_\_\_\_ Date: \_\_\_\_\_ 

**INSURANCE STATEMENT:** Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: Yes No

If yes, Family Insurance Co: \_\_\_\_\_ Contract # \_\_\_\_\_

**CONSENT TO DISCLOSURE:** I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics; and I understand the possibility that serious injury may result from participating in athletic activities. He/She has my permission to accompany the team as a member on its out-of-town trips.

I further understand that my son or daughter will be expected to adhere firmly to all established athletic policies of the school district and the Michigan High School Athletic Association.

Signature of PARENT OR GUARDIAN OR 18 YEAR-OLD \_\_\_\_\_ Date \_\_\_\_\_ 

**MEDICAL TREATMENT CONSENT:** I, \_\_\_\_\_, an 18 year-old, or the parent or guardian of \_\_\_\_\_, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

Signature of PARENT OR GUARDIAN OR 18 YEAR-OLD \_\_\_\_\_ Date \_\_\_\_\_ 