



# 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) Tennis Soccer Girls Volleyball	Swimming Girls Competitive Cheer Bowling Golf

- (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: \_\_\_\_\_ DO MD NP PA 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 STUDENT'S 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 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_



# 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
- Copies of 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	Zip
Father's/Guardian Name: _____		
Phone (home): _____	(work): _____	(cell): _____
Mother's/Guardian Name: _____		
Phone (home): _____	(work): _____	(cell): _____

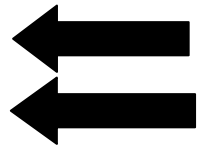
## STUDENT PARTICIPATION & PARENT OR GUARDIAN OR 18 YEAR OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements. Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume; and that I/we agree to, and hereby, waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee-members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA

I/we 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. My child has my permission to accompany the team as a member on its out-of-town trips.

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



**Signature of PARENT OR GUARDIAN OR 18 YEAR-OLD** \_\_\_\_\_ **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: \_\_\_\_\_ Insurance ID # \_\_\_\_\_

**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** \_\_\_\_\_



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?
  - 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 seat belt, use a helmet and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION			
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP _____ / _____	( _____ / _____ )	Pulse _____	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
		Vision R 20/ _____ L 20/ _____	
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart <sup>①</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>②</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>③</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

① Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
 ② Consider GU exam if in private setting. Having third party present is recommended.  
 ③ Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for all sports without restriction.

Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

Not cleared

Pending further evaluation

For any sports

For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

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 physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_ (Circle One) MD DO PA NP

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician 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  Pollens  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 below: <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 <input type="checkbox"/> 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 or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular 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 hernia 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. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
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 \_\_\_\_\_

