PART II — MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

	MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or non prescription (over the counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	☐	☐
6.	Have you ever passed out or nearly passed out during or after exercise?	☐	☐
7.	Have you ever passed out or nearly passed out at any other time?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	☐	☐
10.	Does your heart race or skip beats during exercise?	☐	☐
11.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
12.	Has a doctor ever ordered a test for your heart?	☐	☐
13.	Has anyone in your family died suddenly for no apparent reason?	☐	☐
14.	Does anyone in your family have a heart problem?	☐	☐
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	☐	☐
16.	Does anyone in your family have Marfan syndrome?	☐	☐
17.	Have you ever spent the night in a hospital?	☐	☐
18.	Have you ever had surgery?	☐	☐
19.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐
20.	Have you had any broken or fractured bones or dislocated joints?	☐	☐
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐
22.	Have you ever had a stress fracture?	☐	☐
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐
24.	Do you regularly use a brace or assistive device?	☐	☐
25.	Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27.	Is there anyone in your family who has asthma?	☐	☐
28.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
29.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
30.	Have you had infectious mononucleosis (mono) within the last three months?	☐	☐
31.	Have you ever had mono or any illness lasting more than two weeks?	☐	☐

	MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
32.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
33.	Have you ever had herpes skin infection?	☐	☐
34.	Have you ever had a head injury or concussion?	☐	☐
35.	Date of last head injury or concussion:		
36.	Have you ever been hit in the head and been confused or lost your memory?	☐	☐
37.	Have you ever been knocked unconscious?	☐	☐
38.	Have you ever had a seizure?	☐	☐
39.	Do you have headaches with exercise?	☐	☐
40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
41.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
42.	When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
43.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
44.	Have you had any other blood disorders or amenia?	☐	☐
45.	Have you had any problems with your eyes or vision?	☐	☐
46.	Do you wear glasses or contact lenses?	☐	☐
47.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
48.	Are you happy with your weight?	☐	☐
49.	Are you trying to gain or lose weight?	☐	☐
50.	Do you limit or carefully control what you eat?	☐	☐
51.	Has anyone recommended you change your weight or eating habits?	☐	☐
52.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
53.	What is the date of your last Tetanus immunization? Date: _____		
	FEMALES ONLY		
54.	Have you ever had a menstrual period?	☐	☐
55.	Age when you had your first menstrual period?		
56.	How many periods have you had in the last 12 months?		
57.	Do you take a calcium supplement?	☐	☐
	Explain "Yes" answers here:		

Parent/Guardian Signature:_____

Athlete's Signature:_____

PART III — PHYSICAL EXAMINATION

NAME:_____ SCHOOL:_____

HEIGHT:_____ WEIGHT:_____ SEX: _____ AGE:_____ DOB: _____

*Tanner Stage or Maturation Index? (males only): _____ BP:_____

*Percent Body Fat: _____ Pulse: *(rest) _____

*Audiogram _____ *(Exercise) _____

*(Recovery) _____

*FEV or Peak Flow (rest) _____

* Vision: Corrected: (L) _____ (R) _____ (Both)_____ *(Exercise) _____

Uncorrected (L) _____ (R) _____ (Both)_____ *(Recovery) _____

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ☐ **CLEARED WITHOUT RESTRICTIONS**
- ☐ Cleared **AFTER** further evaluation or treatment for:_____
- ☐ Cleared for **Limited participation** (check and explain "reason" for all that apply):
  - ☐ Not cleared for (specific sports): _____
  - ☐ Cleared only for (specific sports):_____
    Reason(s):_____
- ☐ **NOT CLEARED FOR PARTICIPATION:**_____
  Reason(s):_____
- ☐ Other Recommendations:_____
  - ☐ Recommend monitoring during early conditioning because of weight/fitness/other
  - ☐ Recommend restrictions or monitoring of weight loss or gain
  - ☐ Other: Reasons:_____

MD/DO, PA, NP, DE-SPC#, Signature:_____

Date of Examination:_____ Date Signed:_____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):

_____

Address:_____

City_____ State _____ Zip_____

KNIGHTS

Rocky Mountain Classical Academy