

# MEDICAL HISTORY

- To be completed by parent or guardian or 18-year-old.
- Must be signed below by parent or guardian or 18-year-old.

**A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR**

|                                      |       |              |      |                            |               |            |
|--------------------------------------|-------|--------------|------|----------------------------|---------------|------------|
| STUDENT'S NAME: LAST                 | FIRST | MI           | SEX  | GRADE                      | DATE OF BIRTH | AGE        |
| STUDENT'S ADDRESS: NUMBER AND STREET |       |              | CITY |                            | ZIP           |            |
| NAME OF FATHER OR GUARDIAN           |       | WORK PHONE   |      | NAME OF MOTHER OR GUARDIAN |               | WORK PHONE |
| FAMILY DOCTOR                        |       | OFFICE PHONE |      | STUDENT'S HOME PHONE       |               |            |

## INSURANCE STATEMENT AND MEDICAL HISTORY

Our Son/Daughter will comply with the specific insurance regulations of the school district and the Medical History questions are as complete and correct as possible.

Family Insurance Co: \_\_\_\_\_ Contract #: \_\_\_\_\_

Signatures of Student: \_\_\_\_\_ & Parent/Guardian or 18 Year Old: \_\_\_\_\_

| GENERAL QUESTIONS                                                                                                              | YES | NO | YOUR FAMILY'S HEART HEALTH QUESTIONS                                                                                                                                                                     | YES | NO | MEDICAL QUESTIONS                                                                                                                              | YES | NO |
|--------------------------------------------------------------------------------------------------------------------------------|-----|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Has a Doctor ever denied or restricted your participation in Sports for any reason?                                            |     |    | Does anyone in your family have arrhythmogenic right ventricular cardiomyopathy, long QT syndrome?                                                                                                       |     |    | Do you have any concerns that you would like to discuss with a doctor?                                                                         |     |    |
| Do you have any ongoing medical conditions? If so, please Identify by Circling: Asthma Anemia Diabetes Infections Other: _____ |     |    | 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) ? |     |    | Were you born without or are you missing an organ? Identify by circling: A kidney An eye Your spleen A testicle (males) Any other organ? _____ |     |    |
| Have you ever spent the night in the hospital?                                                                                 |     |    | Does anyone in your family have catecholaminergic polymorphic ventricular tachycardia, short QT syndrome?                                                                                                |     |    | Have you ever had an eating disorder?                                                                                                          |     |    |
| Have you ever had surgery?                                                                                                     |     |    |                                                                                                                                                                                                          |     |    | Do you worry about your weight?                                                                                                                |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU                                                                                               | YES | NO | BONE AND JOINT QUESTIONS                                                                                                                                                                                 | YES | NO | Have you ever had a head injury or concussion?                                                                                                 |     |    |
| Have you ever passed out or nearly passed out DURING or after exercise?                                                        |     |    | Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?                                                                                          |     |    | Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?                                     |     |    |
| Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?                                       |     |    | Have you ever had any broken or fractured bones or dislocated joints?                                                                                                                                    |     |    | Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?                                             |     |    |
| Do you get lightheaded or feel more short of breath than expected during exercise?                                             |     |    | Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace or cast or crutches?                                                                                        |     |    | Have you ever been unable to move your arms or legs after being hit or falling?                                                                |     |    |
| Do you get more tired or short of breath more quickly than your friends during exercise?                                       |     |    | Have you ever been told that you have neck instability or atlantoaxial instability (Down syndrome or dwarfism)?                                                                                          |     |    | Are you trying to or has anyone recommended that you gain or lose weight?                                                                      |     |    |
| Has a doctor ever ordered a test for your heart? For example: ECG/EKG, echocardiogram                                          |     |    | Have you ever had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?                                                                                                 |     |    | Are you on a special diet or do you avoid certain types of foods?                                                                              |     |    |
| Have you ever had an unexplained seizure or do you have a history of seizure disorder?                                         |     |    | Do you regularly use a brace, orthotics, or other assistive device?                                                                                                                                      |     |    | Do you wear protective eyewear, such as goggles, or a face shield?                                                                             |     |    |
| Does your heart ever race or skip beats (irregular beat) during exercise?                                                      |     |    | Do any of your joints become painful, swollen, feel warm or look red?                                                                                                                                    |     |    | Do you or someone in your family have sickle cell trait or disease?                                                                            |     |    |
| Has a doctor ever told you that you have high blood pressure?                                                                  |     |    | Do you have any history of juvenile arthritis or connective tissue disease?                                                                                                                              |     |    | Have you had any problems with your eyes or vision or had any eye injuries?                                                                    |     |    |
| Has a doctor ever told you that you have high cholesterol?                                                                     |     |    | Have you ever had a stress fracture?                                                                                                                                                                     |     |    | Do you wear glasses or contact lenses?                                                                                                         |     |    |
| Has a doctor ever told you that you have Kawasaki disease?                                                                     |     |    | Have you a bone, muscle, or joint injury bothering you?                                                                                                                                                  |     |    | Have you ever had herpes or MRSA skin infection?                                                                                               |     |    |
| Has a doctor ever told you that you have other heart problems?                                                                 |     |    | IMMUNIZATION HISTORY                                                                                                                                                                                     | YES | NO | Have you had infectious mononucleosis (mono) within the last month?                                                                            |     |    |
| Has a doctor ever told you that you have a heart infection?                                                                    |     |    | Are you missing any recommended vaccines (Tdap, Flu, MCV4, HPV, Varicella, MMR)                                                                                                                          |     |    | Do you have any rashes, pressure sores, or other skin problems?                                                                                |     |    |
| Has a doctor ever told you that you have a heart murmur?                                                                       |     |    | MEDICAL QUESTIONS                                                                                                                                                                                        | YES | NO | Do You Have Any Allergies?                                                                                                                     |     |    |
| YOUR FAMILY'S HEART HEALTH QUESTIONS                                                                                           | YES | NO | FEMALES ONLY                                                                                                                                                                                             | YES | NO |                                                                                                                                                |     |    |
| Does anyone in your family have a heart problem, Pacemaker, or implanted defibrillator?                                        |     |    | Have you ever become ill while exercising in the heat?                                                                                                                                                   |     |    | Have you ever had a menstrual period?                                                                                                          |     |    |
| Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, Brugada syndrome?                                |     |    | Do you cough, wheeze, or have difficulty breathing during or after exercise?                                                                                                                             |     |    | How old were you when you had your first menstrual period?                                                                                     |     |    |
| Anyone in your family had unexplained fainting?                                                                                |     |    | Do you have headaches or get frequent muscle cramps When exercising?                                                                                                                                     |     |    | How many periods have you had in the last twelve (12) months?                                                                                  |     |    |
| Anyone in your family had unexplained seizures?                                                                                |     |    | Do you have pain, a painful bulge or hernia in the groin?                                                                                                                                                |     |    |                                                                                                                                                |     |    |
| Anyone in your family had unexplained near drowning?                                                                           |     |    | Is there any one in your family who has asthma?                                                                                                                                                          |     |    |                                                                                                                                                |     |    |
|                                                                                                                                |     |    | Have you ever used an inhaler or taken asthma medicine?                                                                                                                                                  |     |    |                                                                                                                                                |     |    |

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature: \_\_\_\_\_ Signature of: \_\_\_\_\_ Date: \_\_\_\_\_  
Of Student Parent/Guardian

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

## EMERGENCY INFORMATION – To Be Completed by Parent or Guardian or 18 Year Old

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

IN EMERGENCY 1) \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
CONTACT or 2) \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Drug Reactions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

# PHYSICAL EXAM & CLEARANCE & CONSENT FORMS

- To be completed by parent or guardian or 18-year-old.
- Must be signed in **three** places on this page by parent or guardian or 18-year-old.

**A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR**

PLEASE PRINT

|                                |                    |                            |
|--------------------------------|--------------------|----------------------------|
| Last                           | First              | Middle                     |
| STUDENT'S COMPLETE LEGAL NAME: |                    |                            |
| STUDENT'S DATE OF BIRTH:       | Month   Day   Year | PLACE OF BIRTH: City State |
| CIRCLE GRADE: 7 8 9 10 11 12   | SCHOOL:            |                            |

## PHYSICAL EXAMINATION & MEDICAL CLEARANCE

**To be completed by the examining MD, DO, PA or NP & Returned Directly to the patient. Categories may be added or deleted. Check Appropriate Column**

|                                                                                                                                                                       |               |                          |                        |               |                          |               |       |                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------|------------------------|---------------|--------------------------|---------------|-------|-------------------|
| EXAMINATION: (Circle Correct Response As Necessary)                                                                                                                   | Height:       | Weight:                  | Male/Female            | BP: /         | Pulse:                   | Vision: R 20/ | L 20/ | Corrected: Yes No |
| <b>MEDICAL</b>                                                                                                                                                        | <b>NORMAL</b> | <b>ABNORMAL FINDINGS</b> | <b>MUSCULOSKELETAL</b> | <b>NORMAL</b> | <b>ABNORMAL FINDINGS</b> |               |       |                   |
| Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) |               |                          | Neck                   |               |                          |               |       |                   |
| Eyes/Ears/Nose/Throat: Pupils Equal Hearing                                                                                                                           |               |                          | Back                   |               |                          |               |       |                   |
| Lymph Nodes                                                                                                                                                           |               |                          | Shoulder/Arm           |               |                          |               |       |                   |
| Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)                                                               |               |                          | Elbow/Forearm          |               |                          |               |       |                   |
| Pulses: Simultaneous femoral and radial pulses                                                                                                                        |               |                          | Wrist/Hand/Fingers     |               |                          |               |       |                   |
| Lungs:                                                                                                                                                                |               |                          | Hip/Thigh              |               |                          |               |       |                   |
| Abdomen                                                                                                                                                               |               |                          | Knee                   |               |                          |               |       |                   |
| Genitourinary (Males Only)                                                                                                                                            |               |                          | Leg/Ankle              |               |                          |               |       |                   |
| Skin: HSV, lesions suggestive of MRSA, tinea corporis                                                                                                                 |               |                          | Foot/Toes              |               |                          |               |       |                   |
| Neurologic:                                                                                                                                                           |               |                          | Functional: Duck Walk  |               |                          |               |       |                   |

RECOMMENDATIONS:

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities **NOT** crossed out below

BASEBALL - BASKETBALL - BOWLING - COMPETITIVE CHEER - CROSS COUNTRY - FOOTBALL - GOLF - GYMNASTICS  
ICE HOCKEY - LACROSSE - SKIING - SOCCER - SOFTBALL - SWIMMING - TENNIS - TRACK & FIELD - VOLLEYBALL - WRESTLING

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SIGNATURE OF

EXAMINER: \_\_\_\_\_

PRINTED NAME

OF EXAMINER: \_\_\_\_\_

CIRCLE ONE

MD DO PA NP

DATE: \_\_\_\_\_

## STUDENT PARTICIPATION

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 competed 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 West Michigan Christian 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: \_\_\_\_\_

## PARENT OR GUARDIAN OR 18 -YEAR-OLD CONSENT

I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the WMCAA 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 WMCAA

Signature of PARENT OR GUARDIAN OR 18 YEAR-OLD

Date

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

## MEDICAL TREATMENT CONSENT - To Be Completed By Parent or Guardian or 18-Year-Old

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