

**TO BE COMPLETED BY PARENT/GUARDIAN**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

	Yes	No
1. Have you ever been hospitalized?	_____	_____
2. Have you ever had surgery?	_____	_____
3. Are you currently taking and medications or pills?	_____	_____
4. Do you have any allergies? (medication, bees or other stinging insects)	_____	_____
5. Have you ever passed out during or after exercise?	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____
Have you had chest pain during or after exercise?	_____	_____
Do you tire more quickly than your friends during or after exercise?	_____	_____
Have you ever had high blood pressure?	_____	_____
Have you ever been told you have a heart murmur?	_____	_____
Have you ever had racing of your heart or skipped heartbeats?	_____	_____
Has anyone in your family died of heart problems or a sudden death before age 50?	_____	_____
6. Do you have any skin problems? (itching, rashes, acne)	_____	_____
7. Have you ever had a head injury?	_____	_____
Have you ever had a seizure?	_____	_____
Have you ever been knocked out or unconscious?	_____	_____
Have you ever had a stinger, burner or pinched nerve?	_____	_____
8. Have you ever had a heat or muscle cramps?	_____	_____
Have you been dizzy or passed out in the heat?	_____	_____
9. Do you have trouble breathing or do you cough during or after activity?	_____	_____
10. Do you any special equipment? (pads, braces, neck rolls, mouth guard Eye guards)	_____	_____
11. Do you wear glasses or contacts or protective eye wear?	_____	_____
Have you had any problems with your vision or eyes?	_____	_____
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries to any bones or joints? __Head__shoulder__Thigh__neck__elbow__knee__chest__forarm __shin/calf__back__wrist__ankle__hip__foot	_____	_____
13. Have you had any medical problems? (infections, mononucleosis, diabetes)	_____	_____
14. Have you had any medical problems or injury since your last evaluation?	_____	_____
15. When was your last tetanus shot?	_____	_____
16. When was your last measles immunization?	_____	_____
Please explain any "YES" answers _____		
_____		
_____		
_____		

**For Females:**

When was your first menstrual period? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_

What was the longest time between your period last year? \_\_\_\_\_

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

Signature of student athlete \_\_\_\_\_ date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ date \_\_\_\_\_

## Sports Clearance Exam

Name \_\_\_\_\_ School \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Tanner Stage or Maturation Index \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

Pulse \_\_\_\_\_

Vision L 20/\_\_\_\_ R 20/\_\_\_\_ Corrected Y N Pupils \_\_\_\_\_

	Normal	Abnormal		Normal	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			^Neuropsych testing		
Genitals/Hernia (Males only)			^Pelvic examination		

**\*When Medically Indicated**

(Physician judgment based on history, exam, and knowledge of other recent 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 decisions.)

**CLEARANCE**

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

C. Not Cleared for: \_\_\_\_\_ Collision

\_\_\_\_\_ Contact

\_\_\_\_\_ Non Contact \_\_\_\_\_ Strenuous \_\_\_\_\_ Moderately Strenuous \_\_\_\_\_ Non Strenuous

Due to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of Examination \_\_\_\_\_

Name of Medical Provider \_Grand River Primary Care

Address \_\_\_\_\_ 501 Airport Rd. Rifle, CO 81650 \_\_\_\_\_ Phone \_\_\_\_\_ 970-625-1100

Signature of Medical Provider \_\_\_\_\_

**Grand River Health  
501 Airport Rd.  
Rifle, CO 81650  
970-625-1100**