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			^Neuropsyc 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