

Sports Physical Clearance Form

Name: _____ Age: _____ Date of Birth: _____

Parent Permission*: _____ Date: _____

*By signing above I give permission for my child to have a sports physical as required by the CHSAA and that the information provided in the history portion of this form is true and correct to the best of my knowledge.

History (Explain any yes answers in the provided spaces or on back):

1. Allergies to medications, foods or insects? NO/YES

2. Hospitalizations? NO/YES

3. Surgeries? NO/YES

4. Chronic diseases such as asthma, diabetes, high blood pressure, or heart condition? NO/YES

5. Currently taking medication? NO/YES

6. Have you ever lost consciousness (passed out), been knocked unconscious, or had a head injury- to include concussion? NO/YES

7. Have you ever had a seizure? NO/YES

8. During exercise, have you ever gotten dizzy, had chest pain, heart racing, or heart palpitations? NO/YES

9. Do you have trouble breathing or do you cough during or after activity? NO/YES

10. Have you ever sprained/strained, dislocated, fractured, or broken any bones or joints? NO/YES

11. Has anyone in your family died of heart problems or sudden death before age 50? NO/YES

12. Are you missing a kidney, eye, testicle, or any other organ? NO/YES

Physical Examination:

Height:

Weight:

BP:

Pulse:

Musculoskeletal:

Neuro:

HEENT:

Heart:

Pulmonary:

Clearance:

- CLEARED WITHOUT RESTRICTIONS
- Cleared after further evaluation or treatment for _____
- Cleared only for _____
- Recommendations: _____

Name of Provider: _____ Date of Physical: _____

Signature: _____ Date signed: _____