NAME: ______________________ AGE: ______ SEX: _____ DATE: ________

SCHOOL: ______________________ SPORT(S): ______________________

FAMILY HISTORY: Has any member of your family under the age of 50 had the conditions listed below?

YES	NO		YES	NO	
☐	☐	Heart Attack	☐	☐	Diabetes
☐	☐	Sudden Death	☐	☐	Sickle Cell Anemia
☐	☐	Stroke	☐	☐	Arthritis
☐	☐	High Blood Pressure	☐	☐	Epilepsy
☐	☐	Kidney Disease or Abnormalities	☐	☐	Asthma

ATHLETES MEDICAL HISTORY

Have you had any of the below listed conditions?

Last Tetanus: ______________________

YES	NO		YES	NO	
☐	☐	Heart Murmur, irregular or rapid pulse	☐	☐	Recent mononucleosis or enlarged spleen
☐	☐	Chest Pain with or without exercise	☐	☐	Anemia
☐	☐	Heart Disease or Heart Birth Defect	☐	☐	Diabetes
☐	☐	High Blood Pressure	☐	☐	Liver Disease or Hepatitis
☐	☐	Dizzy or Fainting with exercise or heat	☐	☐	TB
☐	☐	Asthma, Cough or Trouble Breathing with exercise	☐	☐	Hernia
☐	☐	Broken Bones, Torn Ligaments or Joint Sprains	☐	☐	Head Injury, Concussion or Knocked Out
☐	☐	Ulcer	☐	☐	Neck Injury, Stinger or Burner
☐	☐	Seizures	☐	☐	Heat Exhaustion/Stroke
☐	☐	Surgery	☐	☐	Regular Medications
☐	☐	Single Testicle	☐	☐	Muscle Pulls

Explain: ____

____

To the best of my knowledge the information given above is true and accurate and grant permission for the physical screening exam. I also understand that the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death.

Parent or Guardian Signature: ______________ Athlete's Signature: ______________ Date: ________

PHYSICAL EXAM: HT: ______ WT: ______ BP: ______ PULSE: ______

VISION: ______ R: ______ L: ______ Glasses or Contacts: YES NO

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEENT	☐	☐	BACK	☐	☐
NECK	☐	☐	UPPER EXT.	☐	☐
LUNGS	☐	☐	LOWER EXT.	☐	☐
HEART	☐	☐	NEURO GROSS	☐	☐
ABDOMEN	☐	☐	HERNIA	☐	☐
OTHER	☐	☐	GU (MALES)	☐	☐

COMMENTS: ____

____

☐ From this limited exam I see no reason why this student cannot participate in all athletic competition.

☐ Student is released to ☐ Contact ☐ Non-Contact ☐ Stress ☐ Moderate ☐ Non-Stress

competition because of ______________ and needs further evaluation regarding ______________.

☐ Not cleared for: ____

Reason: ____

Recommendations: ____

____

Physician : ______________________ Date: ______________

DR. DAVID B. WHEAT

CLINTON FAMILY CARE
309A MORRISON DR.
CLINTON, MS 39056
(601) 924-1877