

Lodi High School
Personal Physician Athletics Clearance Form

PART 1: (To be completed by student and parents/guardian)

Name _____ Grade _____ Student ID _____

Address _____

City _____ Zip _____ Phone () _____

Age _____ Birth Date _____ Sex _____

Year in School: Fr So Jr Sr

Sports—circle all that apply:

Badminton

Soccer

Water Polo

Baseball

Softball

Wrestling

Basketball

Swimming/Diving

Competitive Cheer

Cross Country

Tennis

Drill

Football

Track and Field

Stunt

Golf

Volleyball

Flag Football

Doctor's Name _____ Doctors Phone () _____

Health Insurance _____

Health History

Date of Last Known Tetanus Shot _____

Please Circle (Must be Completed PRIOR to the Exam)

Is there a history of:

Hospitalizations?	Y N	Knee injury?	Y N
Surgery other than removal of tonsils?	Y N	Shoulder or elbow injury?	Y N
Missing organs (eye, kidney, testicle)?	Y N	Ankle injury?	Y N
Allergies (medicines, insects, food)?	Y N	Dislocation of a joint?	Y N
Chest pain or severe shortness of breath with exercise?	Y N	Catching or locking of a joint?	Y N
Problems with blood pressure or heart (heart murmur)?	Y N	Broken bones/fractures?	Y N
Dizziness or fainting with exercise?	Y N	Ulcers or hernias?	Y N
Severe or frequent headaches?	Y N	Stingers/burners?	Y N
Heat exhaustion, heat stroke or other problems with heat?	Y N	Skin problems?	Y N
Seizures/convulsions?	Y N	Mono, hepatitis, hemophilia?	YN
Neck or Back injury?	Y N	Diabetes?	
Concussion of loss or consciousness?	Y N	Has any family member died suddenly at less than 40 years of age of causes other than an accident?	Yes No

Please provide more information, dates, and detail of concussion.

Has any family member had a heart attack at less than 55 years of age? Yes No

Use the space below to explain any yes answers to the above questions.

Parent's or Guardian's Acknowledgment: I have reviewed and agree with the information presented on this form. I also understand that this examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal physician. I know of no reason why the above named student should not participate and represent his or her school in supervised athletic activities.

PRINT Name of Parent/Guardian **Signature of Parent/Guardian**
 () _____ () _____ / _____
 Home Phone Number Work Phone Number Date

PART 2: GENERAL EXAM (To be completed by examining physician)

	NORMAL	ABNORMAL (Describe)	FILL IN INFORMATION
Eyes, Ears, Nose, Throat			
Skin			
Lungs			
Heart			
Abdomen			
Pulse:		Blood Pressure	
Height:		Weight:	

SUGGESTED MUSCULOSKELETAL EXAM

ROM STRENGTH Normal/Abnormal (Circle One)			ROM STRENGTH Normal/Abnormal (Circle One)		
		CERVICAL/SPINE			GENERAL FLEXIBILITY
N	A	Flex/Ext	N	A	Hamstrings
N	A	Rotation right/left	N	A	Quadriceps
N	A	Lateral flexion right/left	N	A	Lumbar Spine
N	A	Thoracic	N	A	Achilles
N	A	Lumbar			LOWER EXTREMITY
N	A	Flex/Ext	N	A	Hip?
N	A	Rotation right/left	N	A	Hip Flexors/Gluteals?
N	A	Lateral flexion right/left	N	A	Add/Abd-Groin/TT?
N	A	Abdominals/Obliques	N	A	Int./Ext. Rotation?
		UPPER EXTRMITY	N	A	Knee?
N	A	Shoulder	N	A	Patellar Tendon?
N	A	Forward flexion/Ext	N	A	Tibial Tuberosity?
N	A	Abduction/adduction	N	A	MCL/LCL?
N	A	Internal/Ext Rotation	N	A	ACL/PCL?
N	A	Horizontal Abd/Add	N	A	Cartilage Testing:
N	A	A C Joint/Clavicle	N	A	Quads/Hamstrings
N	A	Stability Testing	N	A	Gast/Soleus Complex
N	A	Biceps flex/ext	N	A	Patella
N	A	Elbow	N	A	Crepitus
N	A	Supination/Pronation	N	A	Tracking
N	A	Wrist/hand	N	A	Ankle
			N	A	Plantar/Dorsiflexion
			N	A	Inversion/Eversion
			N	A	Subtalar Joint
			N	A	Ligament Testing
			N	A	Feet/Toes

USE THIS SPACE TO DESCRIBE ABNORMALS

DISPOSITION:

- ☐ Cleared for collision, contact and non-contact sports
☐ Conditional participation, limited to: _____
☐ No participation until: _____
☐ No participation in any sport or physical education because of: _____

Doctor's Signature MD
License #
Date