## Lodi High School Personal Physician Athletics Clearance Form

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

NameAddress				
City				
AgeBirth Date	z.ip	Frione ( )		
		Sex		
Year in School: Fr So Jr	Sr			
Sports—circle all that apply:				
Badminton	Soccer		ter Polo	
Baseball	Softball		estling	
Basketball	Swimming/D	•	mpetitive Cheer	
Cross Country	Tennis	Dri	11	
Football	Track and Fi	eld		
Golf	Volleyball			
Doctor's Name				
Health Insurance				
<u>Health History</u>				
Date of Last Known Tetanus Shot				
Please Circle (Must be Completed PRIO	R to the Exam)			
<u>s there a history of:</u>				
Hospitalizations?	ΥN	Knee injury?	Y N	
Surgery other than removal of tonsils?	ΥN	Shoulder or elbow injury?		
Missing organs (eye, kidney, testicle)?	ΥN	Ankle injury?	Y N	
Allergies (medicines, insects, food)?	Y N	Dislocation of a joint?	Y N	
Chest pain or severe shortness of breath	ΥN	Catching or locking of a j	oint? Y N	
with exercise?	ΥN	Broken bones/fractures?	YN	
Problems with blood pressure or heart	ΥN	Ulcers or hernias?	YN	
heart murmur)?	ΥN	Stingers/burners?	YN	
Dizziness or fainting with exercise?	ΥN	Skin problems?	ΥN	
Severe or frequent headaches?	ΥN	•		
Concussion of loss or consciousness?	ΥN			
Heat exhaustion, heat stroke or other	ΥN	Has any family member d	ied suddenly	
problems with heat?	ΥN	at less than 40 years of ag		
Mono, hepatitis, hemophilia?	ΥN	other than an accident?		No
Diabetes?	ΥN			
Seizures/convulsions?	ΥN	Has any family member h	ad a heart	
Neck or Back injury?	ΥN	attack at less than 55 year		No
3 2		,	C	
		Use the space below to e	xplain anv	
		yes answers to the above		
		<b>3</b>	1	
Parent's or Guardian's Acknowledgm	ent: I have revi	ewed and agree with the infor	mation presented on t	his for
I also understand that this examination is				
the routine health care visits as recomme				
above named student should not participation				
	/			
PRINT Name of Parent/Guardian	n	Signature of Parent/C	Guardian	
( )( )_		//		
Home Phone Number	Work Phone	Number	Date	

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

That I de terminate of the series,					
	NORMAL	ABNORMAL (Describe)	FILL IN INFORMATION		
Eyes, Ears, Nose, Throat					
Skin					
Lungs					
Heart					
Abdomen					
Pulse:		Blood Pressure			
Height:		Weight:			

## SUGGESTED MUSCULOSKELETAL EXAM

RO	OM STRENGTH		RON	4 STRENGTH	
No	ormal/Abnormal		Normal/Abnormal		
	(Circle One)		(	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 T	HIS SPACE TO DESCRIBE ABNORMALS					
DISPO	SITION:					
	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			