ELEM INDIAN COLONY

Release of Information to a Third-Party Authorization Form

Federal and state laws limit Elem’s ability to discuss personal information about a participant with anyone other than the participant, unless the participant authorizes in writing the release of such information. It is necessary for the Program Coordinator and Fitness Coordinator for Elem Indian Colony to work with third party affiliates during this fitness program. LCTHC is a strategic partner in this program in the way of nutrition and other diet related collaboration. If you have questions about this form, please contact the Fitness Coordinator for further information.

Instructions to Members/Participants

This form must be completed and sent to: Elem Indian Colony PO Box 757 Lower Lake, CA 95457

Or fax to: (707) 994-3408

Please print clearly, as all information provided must be legible. Form will be returned if not legible or incomplete.

Member’s Name __________________________________________

Roll Number_________________________________________ E-mail: __________________________

Phone Number: _________________________________________


Name of person(s)/agency authorized to obtain information:

LCTHC

Authorization to Release Information

☐ I authorize the above-named individual(s) or agency to talk with EIC staff about, and have access to, all information related to my FITNESS participation. I understand that this authorization will be in effect until I notify the EIC that I wish to revoke it.

on (date)______________________________________________

Participant Signature________________________________ Date _________________________
Dear Tribal Member,

Welcome to the EIC Fitness Program. We are excited that you have chosen to participate in an exercise activity program specifically designed for you. Before we begin the following forms need to be completed so we can provide you with a program that is right for you.

To be completed before your first exercise activity session:

- Health History Questionnaire Physical Activity Readiness Questionnaire (PAR-Q)
- Training Contract Agreement (copy for Client)
- Fitness Coordinator/Client Code of Conduct (copy for Client)
- Consultation with Coordinator
- Make an appointment for first training session

All participants ARE REQUIRED to have a Medical Release Form completed and on file prior to participating in any form of exercise activities.
Physical Activity Questionnaire
To help us get an idea of how familiar you are with different exercises and activities.

1. How did you hear about our PT program?

__________________________________________________________________________

2. Have you ever performed resistance training exercises in the past?
   Yes ______ No ______
   (Movement against a resistance such as dumbbells, weight machines, bands, or bodyweight)

3. How often do you participate in physical activity?
   ___ Never    ___ 1-3 times/month ___ 1-2 times/wk. ___ 4-5 times/wk.

4. When doing physical activity, for how long do you remain active?
   ___ NA ___ 20 Minutes ___ 30 Minutes ___ 1 Hour ___ > 1 Hour

5. At what intensity are you physically active? Choose your ability to talk during exercise.
   ___ NA ___ Able to talk ___ Able to talk but not sing ___ Not able to say more than a few words.

6. Did you know that people who schedule activity are more likely to be active?
   What time of day works for you to be active? ________________________________

7. Did you know that people who are active with a partner are more likely to be consistently active?
   Who is a potential workout partner for you? ________________________________
   Will you be willing to ask them to be active with you? Y / N
8. Did you know people who are active on a regular basis tend to be in touch with the “feel good” feelings immediately after activity?

How do you usually feel before physical activity? ________________________________

How do you usually feel after easy or moderate physical activity? ________________

9. Daily Activity: Moving daily can be very beneficial long term; small changes add up for both physical and psychological benefits. Which activities could you add this week without much effort?

Which could you add within two weeks?

_____ Park near the back lots  _____ Stairs instead of elevators
_____ Walk to school/work/out  _____ Bike to school/work/out
_____ One active errand (no car)  _____ Walk from one bus stop away
_____ Other: ______________________

10. Aerobic Exercise: Moving for just 10 minutes at low to moderate intensity routinely can help improve sleep, mood, energy level, cognitive functioning, self-esteem, endurance, cardiovascular health, overall quality of life.

Which activities do you currently enjoy?

€ Walking  € Jogging  € Hiking  € Rowing
€ Cycling  € Dance/Zumba  € Racquet sports  € Frisbee
€ Stationary bike  € Elliptical  € Yoga/Pilates  € Competitive Sports
€ Stair climbing  € Swimming  € Spin cycle  € Water Running
€ Other __________________________

Which activities would you like to try?

______________________________

11. Resistance Training: Activity that causes the muscles to contract against an external resistance such as dumbbells, bands or by use of your own body weight can lead to benefits in strength, posture, bone health, tone, and endurance.

Which activities do you currently enjoy?

€ Strength Training  € Calisthenics  € Yard Work  € Yoga
€ Rock Climbing  € Core Workouts  € Physical Work  € Cross Fit
€ Other __________________________

Which activities would you like to try?

______________________________
12. People who identify potential barriers and possible alternatives/solutions before they are active are more likely to be successful. Many of these "excuses" are only perceived. For example, most people say they do not have time to be active; in reality, their biggest barrier is their self-talk and their tendency to talk themselves out of exercising and not talking themselves into being active.

What is your biggest barrier? ________________________________

What is one possible solution to this barrier? ________________________________

13. List in order your health and fitness objectives.

1. ________________________________

2. ________________________________

3. ________________________________

Examples
Overcome hesitation with movement
Learn how to use the machines/weights
Make a connection with other people
Find new fun activities
See what the Recreation Center has to offer
Gain more confidence
Improve sleep
Improve strength
Improve flexibility
Increase energy
Participant Application/Questionnaire

Primary Health Care Provider

Doctor: __________________________ Phone: __________________________
Address: __________________________________________________________
When were you last seen by a physician? __________________________________

Present/Past History

1. Have you had surgery within the last 2 years? Yes____ No____
   If yes, please explain below: _______________________________________

2. Do you have any past or present orthopedic injuries? Yes____ No____

3. Are you taking any medications (prescribed or not)? Yes____ No____
   Please list below: _________________________________________________

4. Are you taking any supplements or vitamins? Yes____ No____
   (examples: vitamins, minerals, herbs, enzymes, amino acids, organ tissue)
   Please List: ______________________________________________________
   ________________________________________________________________
5. Do you follow or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits?

6. Please check all conditions that you currently have or have had in the past.

- Heart attack
- Diabetes
- Stroke
- Chest discomfort
- Heart murmur
- Trouble sleeping
- Migraine or headache
- Broken Bone
- Shortness of breath
- Anemia
- Asthma
- Epilepsy
- Anxiety
- Depression
- Fatigue
- Hernia
- Arthritis
- Limited range of motion
- Pain

Explain any conditions that you checked (i.e. treatment, symptoms, restrictions):

7. Which of the following areas would you like more information about? Check all that apply.

- Alcohol use
- Drug use
- Sexual health
- Sexual Assault
- Time management
- Emotional health
- Relationships
- Body image
- Stress management
- Smoking cessation
- Anxiety
- Women’s health
- Men’s health
- Depression
- Avoiding illness
- Addiction
- Family health history
- Alternative providers
- Sleep
- Nutrition
- Environmental health
- Food Safety
- Social Activities
- Other __________________________

I acknowledge that I am in good health, have answered the previous questions truthfully, and have no known medical problems that would preclude safe participation in this exercise program.

Signed: ___________________________ Date: ______________
Participant Application/Questionnaire

Physical Activity Readiness Questionnaire (PAR-Q)

Every participant must sign the Waiver form prior to engaging in any activities. This form can be obtained from Elem Indian Colony Website or at the front desk at the Administration.

Regular exercise is associated with many health benefits, yet any change of activity may increase the risk of injury. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly.

<p>| | | | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>y</td>
<td>N</td>
<td>Has a physician ever said you have a heart condition, and you should only do physical activity recommended by a physician?</td>
<td></td>
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<tr>
<td>y</td>
<td>N</td>
<td>When you do physical activity, do you feel pain in your chest?</td>
<td></td>
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<tr>
<td>y</td>
<td>N</td>
<td>When you were not doing physical activity, have you had chest pain in the past month?</td>
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<td>y</td>
<td>N</td>
<td>Do you ever lose consciousness, or do you lose your balance because of dizziness?</td>
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<tr>
<td>y</td>
<td>N</td>
<td>Do you have a joint or bone problem that may be made worse by a change in your physical activity?</td>
<td></td>
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</tr>
<tr>
<td>y</td>
<td>N</td>
<td>Is a physician currently prescribing medications for your blood pressure or heart condition?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>y</td>
<td>N</td>
<td>Are you pregnant or post-partum?</td>
<td></td>
<td></td>
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<tr>
<td>y</td>
<td>N</td>
<td>Do you have insulin dependent diabetes?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>y</td>
<td>N</td>
<td>Are you a man over the age of 45 or a woman over the age of 55?</td>
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<tr>
<td>y</td>
<td>N</td>
<td>Do you know of any other reason you should not exercise or increase your physical activity?</td>
<td></td>
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</tr>
</tbody>
</table>

No to all questions: If you answered NO honestly to all PAR-Q questions you can be reasonably sure that you can become more physically active and take part in a fitness training program.

Note: If your health changes so that you then answer YES to any of the above questions, tell your fitness instructor, and ask whether you should change your physical activity plan.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Participant's signature: ___________________________ Date: ___________

Signature of witness (Coordinator): ___________________________ Date: ___________
CONTRACT AGREEMENT

In order to see improvements towards your health, fitness, and or performance goals, it’s imperative for you to follow programming protocols both during supervised and (if applicable) unsupervised training days. While working with us, every effort will be made to ensure your safety; however, as with any exercise/activity program, there are inherent risks. These risks include, but are not limited to, increased heart stress and chances of musculoskeletal injuries. In signing up for this program, you agree to assume responsibility for the mentioned inherent risks and waive any possibility for personal damage.

A Medical Release form is mandatory for all participants. Personal training participants who do NOT have a prior medical examination MUST acknowledge that they have been informed of its importance. By signing below, you accept full responsibility for your own health and well-being.

1. CANCELLATIONS must be made 24 hours in advance of schedule training appointments. If you can't contact your Coordinator, then call Kim Cavagna at 707-513-3200 and leave a message.

2. Program will last for a total of (9) Months

I (Client Name-Please Print) agree to the best of my knowledge, that I have no limiting physical conditions or disabilities that would preclude myself from participating in an exercise/activity program with the Coordinator at the fitness center designated (Clearlake, Lakeport, or Hidden Valley).

Clients Signature):_________________________________________ Date:________

Witness (Trainer) Signature:_________________________________ Date:______
# Preparticipation Physical Evaluation

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam

Name

Sex Age Grade School Sport(s)

Date of birth

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

- [ ] Medicines
- [ ] Pollens
- [ ] Food
- [ ] Stinging Insects

Do you have any allergies?  
- [ ] Yes  
- [ ] No  
If yes, please identify specific allergy below.

Explain "Yes" answers below. Circle questions you don't know the answers to.

### GENERAL QUESTIONS

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
</tr>
</tbody>
</table>
| 2. Do you have any ongoing medical conditions? If so, please identify below: [ ] Heart murmur  
[ ] Asthma  
[ ] Anemia  
[ ] Diabetes  
[ ] Infections  
[ ] Other: | |
| 3. Have you ever spent the night in the hospital? | |
| 4. Have you ever had surgery? | |

### HEART HEALTH QUESTIONS ABOUT YOU

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
</tr>
<tr>
<td>7. Does your heart race or skip beats (irregular beats) during exercise?</td>
<td></td>
</tr>
</tbody>
</table>
| 8. Has a doctor told you that you have any heart problems? If so, check all that apply:  
[ ] High blood pressure  
[ ] A heart murmur  
[ ] High cholesterol  
[ ] A heart infection  
[ ] Kawasaki disease  
[ ] Other: | |
| 9. Has a doctor ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | |
| 11. Have you ever had an unexplained seizure? | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | |

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?</td>
<td></td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?</td>
<td></td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
</tr>
<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
</tr>
</tbody>
</table>

### BONE AND JOINT QUESTIONS

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game?</td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
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<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
</tr>
<tr>
<td>21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)</td>
<td></td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive devices?</td>
<td></td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
</tr>
<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
</tr>
</tbody>
</table>

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete

Signature of parent/guardian

Date

# Preparticipation Physical Evaluation

## The Athlete with Special Needs: Supplemental History Form

Date of Exam ______________________________ Date of birth ______________________________

Name ______________________________ Grade __________ School ______________________________ Sport(s) __________

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Date of disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Classification (if available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Cause of disability (birth, disease, accident/trauma, other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. List the sports you are interested in playing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthesis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
<td></td>
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<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
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<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
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<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
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<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></td>
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</tbody>
</table>

Explain "yes" answers here

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
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<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________________________ Signature of parent/guardian ______________________________ Date __________

## Preparticipation Physical Evaluation

**Physical Examination Form**

### Name

**Date of birth**

### Physician Reminders

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### Examination

<table>
<thead>
<tr>
<th>Examination</th>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
<td>(</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>Vision R 20/</td>
<td>L 20/</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Marfan (high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes, ears, nose, throat</td>
<td>Pupil equal</td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
</tr>
<tr>
<td>Heart*</td>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
</tr>
<tr>
<td>Location of point of maximal impulse (PMI)</td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td>Simultaneous femoral and radial pulses</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)*</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>HSV lesions suggestive of MRSA, linea corporis</td>
</tr>
<tr>
<td>Neurologic*</td>
<td></td>
</tr>
</tbody>
</table>

### Musculoskeletal

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder/arm</td>
<td>Elbow/forearm</td>
</tr>
<tr>
<td>Elbow/hand/forearm</td>
<td>Wrist/hand/forearm</td>
</tr>
<tr>
<td>Hip/thigh</td>
<td>Knee</td>
</tr>
<tr>
<td>Leg/ankle</td>
<td>Foot/toes</td>
</tr>
<tr>
<td>Functional</td>
<td>Duck-walk, single leg hop</td>
</tr>
</tbody>
</table>

*Consider EKG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GU exam if in private setting, having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- [ ] Cleared for all sports without restriction
- [ ] Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______

- [ ] Not cleared
  - [ ] Pending further evaluation
  - [ ] For any sports
  - [ ] For certain sports ______

Reason ______

Recommendations ______

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) __________ Date __________

Address __________ Phone __________

Signature of physician __________ MD or DO

Preparticipation Physical Evaluation
CLEARANCE FORM

Name ______________________________ Sex □ M □ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared
   ☐ Pending further evaluation
   ☐ For any sports
   ☐ For certain sports

Reason ______________________________________________________

Recommends ________________________________________________

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________ Date __________
Address ______________________________________________ Phone _________
Signature of physician __________________________, MD or DO

EMERGENCY INFORMATION

Allergies ____________________________________________________

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Other information ___________________________________________

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________