Tokay 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	Golf	Track and Field
Baseball	Soccer	Volleyball
Basketball	Softball	Water Polo
Cross Country	Swimming/Diving	Wrestling
Football	Tennis	Sideline Cheer

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	Y N	Catching or locking of a joint?	Y N
with exercise?	Y N	Broken bones/fractures?	Y N
Problems with blood pressure or heart	Y N	Ulcers or hernias?	Y N
(heart murmur)?	Y N	Stingers/burners?	Y N
Dizziness or fainting with exercise?	Y N	Skin problems?	Y N
Severe or frequent headaches?	Y N	Mono, hepatitis, hemophilia?	YN
Heat exhaustion, heat stroke or other	Y N	Diabetes?	
problems with heat?	Y N	Has any family member died suddenly at	
Seizures/convulsions?	Y N	less than 40 years of age of causes other	
Neck or Back injury?	Y N	than an accident?	Yes No
Concussion of loss or consciousness?	Y N		
Please provide more information, dates,		Has any family member had a heart attack	
and detail of concussion.		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