EAGLES

Ronald E. McNair High School
9550 Ronald E. McNair Way Stockton, Ca 95210
Athletic Office Phone Number 209-459-8901

Physician Athletics Clearance Form

PART 1: (To be completed by Athlete)

Name _____ Athlete's ID_____

Address_____

City _____ Zip _____ Phone ( ) _____

Age _____ Birth Date _____Grade in School as of Aug 1_____ Gender _____

Doctor's Name _____ Doctor's Phone ( ) _____

Health Insurance #_____

Date of Last Known: Tetanus Shot _____ Polo _____ Diphtheria _____

Health History Please Circle

Is there a history of:

Hospitalizations?	Y N	Knee injury?	Y N	Broken bones/fractures?	Y N
Surgery other than removal of tonsils?	Y N	Shoulder or elbow injury?	Y N	Ulcers or hernias?	Y N
Missing organs (eye, kidney, testicle)?	Y N	Ankle injury?	Y N	Stingers/burners?	Y N
Allergies (medicines, insects, food)?	Y N	Dislocation of a joint?	Y N	Diabetes?	Y N
Chest pain or severe shortness of breath with exercise?	Y N	Catching/locking of a joint?	Y N	False teeth	Y N
Problems with blood pressure or heart (heart murmur)?	Y N	Mono, hepatitis, hemophilia?	Y N	Nosebleeds	Y N
Dizziness or fainting with exercise?	Y N	Skin problems	Y N		
Severe or frequent headaches?	Y N	Seizures/convulsions?	Y N		
Heat exhaustion, heat stroke or other problems with heat?	Y N	Neck or Back injury?	Y N		
Neck or Back injury?	Y N				
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? Y N

Has any family member had a heart attack less than 55 years of age? Y N

Please provide more information,dates, and details of concussion. Use the space below to explain any **YES** answers to the above questions.

_____

_____

_____

Athlete's Acknowledgement: 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 Athlete **Signature of Athlete**

( ) _____ _____

Phone Number **Date**

MUST UPLOAD BOTH SIDES IN ARBITER

Print Name Of Athlete_____

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_____

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

Use this space to list any 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 :_____

_____ / _____/ _____

Signature of Doctor **License Number** **Date**

MUST UPLOAD BOTH SIDES IN ARBITER