

Well Exam - Sports Participation Clearance Form

NOTE: How often a clearance form is needed to play sports, is determined by your school. This clearance form is the only Sports Participation Clearance Form supported by the Vermont Principals' Association, the Vermont Departments of Health and Education, and the Vermont Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. The American Academy of Pediatrics Council on Sports Medicine and Fitness developed the research based screening activities done during a Well Exam, to determine sports readiness.

Student's Name _____

Age _____ Date of Birth _____ Grade _____

This Athlete is:

Cleared without restriction

Cleared, **with restrictions:**

Not cleared for: All sports

Certain sports: _____

Reason: _____

Relevant Medical Information for Coaches and Athletic Department:

Allergies: _____ EpiPen Necessary: Yes No

Asthma: Yes No Emergency Medications: _____

Diabetes: Yes No Emergency Medications: _____

Seizure Disorder: Yes No Emergency Medications: _____

Well Exam using ICD-9-CM code:

99383 or 99393

5 - 11 years

99384 or 99394

12 - 17 years

99385 or 99395

18 - 39 years

NOTE: Clearance form is not valid unless one of these Well Exam codes is checked by Practitioner

Comments: _____

Name of Practitioner (print/type): _____ Practitioner Phone # _____

Signature of Practitioner: _____ Date of Exam: ___/___/___

Suggestion for Athletic Department: Please make copy for School Nurse's Office records

Preparticipation Physical Evaluation

HISTORY FORM

DATE OF EXAM _____

Name _____	Sex _____	Age _____	Date of birth _____
Grade _____ School _____		Sport(s) _____	
Address _____		Phone _____	
Personal physician _____			
<i>In case of emergency, contact:</i>			
Name _____		Relationship _____	Phone (H) _____ (W) _____

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

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | | 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure | | | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol | | | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart murmur | | | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart infection | | | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/fingers | Chest |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes |
-
- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | 47. FEMALES ONLY Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | 48. How old were you when you had your first menstrual period? _____ | | |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | 49. How many periods have you had in the last 12 months? _____ | | |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | 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 _____