Medical Clearance – Cal Sport Clubs – History

Date of Birth:

Student ID:

Name _____ Date of Exam _____

Sex M F I T Gender _____ Sport(s) _____

	Yes	No
P1. Do you have any ongoing or chronic illness? (diabetes, migraine headaches or asthma)		
If yes, what:		
If yes, is it well-controlled?		
P2. Have you ever been hospitalized overnight?		
P3. Are you currently taking any prescription or non-prescription medications, pills, or using an inhaler?		
P4. Do you have allergies to any medications, pollens, foods, or stinging insects?		
P5. Do you have a broken, chipped, or loose tooth, or dental plate?		
P6. Are you missing one of the following: kidney, eye, testicle (or an undescended testicle)?		
P7. Do you follow a specific diet?		
P8. Have you had a weight loss greater than ten pounds?		
P9. Has anyone recommended you change your weight or eating habits?		
P10. Have you had problems with your eyes or vision including prior injury?		
P11. Do you wear glasses, contacts, or protective eyewear? Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters, MRSA, or herpes skin infection)?		
CV1. Have you ever passed out or nearly passed out DURING and/or AFTER exercise?		
CV2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
CV3. Does your heart ever race or skip beats (irregular beats) during exercise?		
CV4. Has a doctor ever told you that you have any heart problems? If YES to any, circle which: High blood pressure, High cholesterol, Kawasaki disease, Heart murmur, Heart infection		
CV5. Have you had any tests for your heart?		
CV6. Do you get lightheaded, have difficulty breathing or feel more short of breath than expected during exercise?		
CV7. Has any family member or relative died of heart problems or died suddenly before the age of 50?		
CV8. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
CV9. Has anyone in your family had unexplained fainting, seizures, or near drowning?		
CV10. 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?		
CV11. Have you ever become ill from exercising in the heat?		
CV12. Has a doctor told you that you or someone in your family has sickle cell trait/disease or thalassemia?		
CV13. Have you had COVID?		
If yes, when were the dates:		

	Yes	No
N1. Have you ever had a head injury or concussion?		
N2. Have you ever been hit in the head and been confused, had a prolonged headache, or lost your memory?		
N3. Have you ever had a seizure?		
N4. Do you have frequent or severe headaches?		
N5. Do you have headaches with exercise?		
N6. Do you have groin pain or a painful bulge or hernia in the groin area?		
N7. Have you ever had pain, numbness AND/OR tingling in your arms, hands, legs, or feet after being hit or falling?		
O1. Has a physician ever denied or restricted your participation in sports for any reason?		
O2. Have you ever had surgery?		
O3. Do you currently have a bone, muscle, or joint injury that bothers you?		
O4. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?		
O5. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
O6. Have you broken/fractured any bones or dislocated any joints?		
O7. Have you had a bone or joint injury that required x-rays, MRI, CT surgery, injections, rehab, physical therapy, brace, cast or crutches?		
O8. Have you ever had a stress fracture?		
If yes, which body part:		
Is it still bothering you?		
B1. Do you use tobacco products?		
If yes, type of tobacco:		
Packs/Cartridges per day _____ Years smoked _____		
B2. Many people feel depressed at times. Please rate any feelings of depression you may have: Use a number from 0 (none) – 10 (severe)		
B3. Would you like to know more about mental health resources?		
B4. Would you like to know more about nutrition services?		
B5. Would you like to know more about sexual health resources?		
B6. Would you like to know more about time or stress management resources?		
G1. Have you ever had a menstrual period?		
G2. How old were you when you had your first menstrual period?		
G3. Do you have a monthly period?		
If no, explain:		
G4. What is the longest time (in months) you have gone without a period?		

If yes to any questions, explain below:

My answers to the above questions are complete and correct.

_____

Signature of student athlete Date

I have reviewed the questions with the student athlete.

_____

Signature of clinician (MD/DO/PA/NP): Date

Medical Clearance – Cal Sport Clubs – Physical Exam

Vision: Right 20/ Left 20/ Bilateral 20/ Corrected: Y N

Height _____ Weight _____ BMI _____ Pulse _____ Blood Pressure _____

Date of Birth:

Student ID:

Nml	Abn	General/Internal	Comments
☐	☐	Head	
☐	☐	Eyes	
☐	☐	ENT	
☐	☐	Lymph Nodes	
☐	☐	Lungs	
☐	☐	Abdomen	
☐	☐	GU	
☐	☐	Skin	
☐	☐	Neurological	

Nml	Abn	Cardiovascular	
☐	☐	BP (sitting)	
☐	☐	Auscultation	
☐	☐	Pulses	

Nml	Abn	Musculoskeletal	Comments
☐	☐	Neck	
☐	☐	Spine	
☐	☐	Shoulders	
☐	☐	Back	
☐	☐	Arms	
☐	☐	Elbows	
☐	☐	Wrists	
☐	☐	Hands	
☐	☐	Hips	
☐	☐	Thighs	
☐	☐	Knees	
☐	☐	Ankles	
☐	☐	Feet	

COVID-19

This patient had a confirmed case of COVID-19: ☐ Yes ☐ No

This patient was ☐ asymptomatic **OR** ☐ symptomatic during their COVID-19 infection.

The patient meets the currents standards for returning to athletic activity after a COVID-19 infection without restriction: ☐ Yes ☐ No ☐ N/A

If 'No', indicate follow up plan:

_____

Assessment/Plan

Any pre-existing injury/illness?

Medical Y N

Ortho Y N

Student athlete cleared to Participate

Medical Y No, follow up needed:

Ortho Y No, follow up needed:

Signature of clinician (MD/DO/PA/NP) **Date**