

2019-2020 Physical Screening and Physician Authorization Form

This is not a School District sponsored event

Not printed at School District expense



Student's Legal Name: _____	Home Phone Number: _____
Home Address: _____	Date of Birth: _____
School Group: _____	Age: _____

Your Medical History:

Answer the following questions prior to the appointment with the Doctor. "Yes" answers require a detailed explanation.

1. Have you ever sustained an injury which prevented you from playing sports for more a day? **Yes No**
2. Are you allergic to any medication? **Yes No** (describe) _____
3. Do you have any family history of medically unexplained or cardiac caused sudden death under age 50? **Yes No**
4. Do you have any family history of Long QT Syndrome or unexplained fainting or seizures? **Yes No**
5. Females Only – Dates of most recent menstrual period: _____
6. Have you had any injuries, pain or swelling to the following areas? (Circle all that apply)

Head	Chest	Elbows	Hands	Hips	Knees	Ankles	Neck	Arms	Shoulders	Wrists
Fingers	Thighs	Shins	Calves	Feet	Back	Other: _____				

7. Do you have a history of and/or take medication for any medical problem listed below (Circle all that apply)

Viral Infections	Heart Conditions	Asthma	Easily tired	Dizziness	High or Low Blood Pressure
Illness from Heat	Chest Pain	Seizures	Rash or Hives	Fainting	High or Low Cholesterol
Difficulty Breathing	Broken Bones	Diabetes	Hospitalization	Allergies	Severe Headaches
Skin Conditions	Concussion	Numbness	Joint Pain	Surgery	Any other Conditions

Other: _____

I, (print name) _____, give my consent on behalf of my son/daughter (or the minor for whom I am legal guardian), as named above, to participate in and receive a physical screening exam. This exam may include an unclothed exam by a licensed health provider as well as urine, vision, & blood pressure screening. I understand that this examination is intended for the purpose of screening for participation in the We Run Our Community's Kids marathon training program. I also consent to the release of information by the screening institution to representatives of We ROCK. I also hereby state that, to the best of my knowledge, my answers to the questions above are complete and correct.

Parent/Guardian Signature: _____ Date: _____

For Physician Use Only: (Please complete, sign, date and affix your stamp)

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temperature: _____ Respiration: _____

Please circle any areas of concern:

Eyes	Ears	Neck	Back	Nose	Shoulders	Throat	Elbows	Hands	Wrists	Skin
Arms	Forearms	Legs	Ankles	Lungs	Pulse	Hips	Thighs	Heart	Knees	Hernia
Abdomen	Feet	Lymph Nodes	Blood Pressure	Other: _____						

Screening Results (please circle): **Satisfactory Recommend Further Evaluation** (Reason: _____)

May this individual continue to train and participate in the 19-20 We ROCK program? **Yes No**

Physician Signature: _____ Date: _____

Physician Name (print): _____ Stamp: _____