

WeROCK – We Run Our Community's Kids
25-26 PHYSICAL CLEARANCE FORM



Name: _____ Grade in 2025/2026: _____ Male: _____ Female: _____ DOB: _____

Address: _____ City & Zip: _____

Father/Guardian: _____ Work Phone: _____ Cell Phone: _____

Mother/Guardian: _____ Work Phone: _____ Cell Phone: _____

Alternate Emergency Contact: _____ Phone: _____ Insurance: _____

***I hereby give my consent for the above-named student (son/daughter/ward) to compete in sports and to go with representatives of WeROCK on any trips. In case of injury, you are authorized to have him/her/they treated.

SIGNATURE OF PARENT/GUARDIAN _____ Date: _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/GUARDIAN BEFORE DOCTOR EXAM

Any past or present	Yes	No		Yes	No
Problems with vision	_____	_____	Surgeries	_____	_____
Eyeglasses	_____	_____	Dental Problems	_____	_____
Contacts	_____	_____	Braces	_____	_____
Problems with hearing	_____	_____	False Teeth	_____	_____
Hearing Aid	_____	_____	Painful Joints	_____	_____
Blacking out or fainting	_____	_____	Broken Bones	_____	_____
Unconsciousness	_____	_____	Body Part: _____		
Convulsions	_____	_____	Knee or ankle problems	_____	_____
Seizures	_____	_____	Require support/brace	_____	_____
Heart Problems	_____	_____	Need for medication	_____	_____
Rheumatic fever	_____	_____	Name: _____		
Bleeding Disorders	_____	_____	Menstruation Problems	_____	_____
Blood Sugar Problems	_____	_____	Hernias	_____	_____
Hypoglycemia	_____	_____	Asthma	_____	_____
Diabetes	_____	_____	OTHER HEALTH ASPECTS THE DOCTOR &		
Allergies – type: _____			WEROCK SHOULD BE AWARE OF: _____		
Bee or insect stings	_____	_____	_____		
Hospitalizations	_____	_____	_____		
Any history of chest pain with exercise?				_____	_____
Any history of “racing” heart or skipped beats?				_____	_____
Do you experience passing out, near passing out or unexpected tiredness during exercise?				_____	_____
Any family history of sudden cardiac death in family member under the age of 50?				_____	_____
Any family history of Marfan’s syndrome or prolonged QT syndrome?				_____	_____
Any history of temporary numbness or paralysis of both arms and/or legs following head/spine trauma?				_____	_____
Any history of recent severe viral illness, infectious mononucleosis, or hepatitis?				_____	_____
Any history of the following: absence of one kidney?				_____	_____
Males: absence of one testicle?				_____	_____
Any history of blindness in one eye?				_____	_____
Any current active skin infections?				_____	_____

PHYSICAL EXAM: (Physician/Physician’s asst./Nurse Practitioner)

HEIGHT: _____ WEIGHT: _____

RESTING PULISE: _____	AFTER ACTIVITY PULSE: _____	B.P.: _____
EYES: _____	THROAT: _____	ABDOMEN: _____
EARS: _____	LYMPH: _____	GLANDS: _____
TEETH: _____	THYROID: _____	POSTURE: _____
BRACES: _____	HEART: _____	MUSCLE TONE: _____
NOSE: _____	LUNGS: _____	REFLEXES: _____
		ORTHOPEDIC: _____
		HERNIA SKIN: _____
		OTHER: _____

I have examined the above student and do recommend that he/she is physically fit for full participation in marathon training. CIRCLE ONE: YES NO

Special doctor recommendations or restrictions: _____

(Must be signed by a PHYSICIAN, PHYSICIAN’S ASSISTANT OR NURSE PRACTITIONER and include the Physician’s office stamp to be valid)

Name of Physician: _____ MD/DO/PA/NP Date: _____

Signature: _____ Phone: _____

****Physician’s Office Stamp****

