

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

Name: \_\_\_\_\_ Grade in 2025/2026: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City &amp; 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	_____	_____	<b>OTHER HEALTH ASPECTS THE DOCTOR &amp; WEROCK SHOULD BE AWARE OF:</b> _____	_____
Allergies – type: _____	_____	_____	_____	_____
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 PULSE: _____	AFTER ACTIVITY PULSE: _____	B.P.: _____
EYES: _____	THROAT: _____	ABDOMEN: _____
EARS: _____	LYMPH: _____	GLANDS: _____
TEETH: _____	THYROID: _____	POSTURE: _____
BRACES: _____	HEART: _____	MUSCLE TONE: _____
NOSE: _____	LUNGS: _____	REFLEXES: _____
		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\*\***