2020-2021 Physical Screening and Physician Authorization Form

This is not a School District sponsored event

Not printed at School District expense

WE ROCK 10 YEARS

We Run Our Community's Kids

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 20-21 We ROCK program? **Yes** **No**

Physician Signature: Date:

Physician Name (print): Stamp: