

**2021-2022 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: _____
Training Campus: _____	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)

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

7. Do you have a history of and/or take medication for any medical problem listed below (Circle all that apply)
- |                             |                         |                 |                        |                  |                                   |
|-----------------------------|-------------------------|-----------------|------------------------|------------------|-----------------------------------|
| <b>Viral Infections</b>     | <b>Heart Conditions</b> | <b>Asthma</b>   | <b>Easily tired</b>    | <b>Dizziness</b> | <b>High or Low Blood Pressure</b> |
| <b>Illness from Heat</b>    | <b>Chest Pain</b>       | <b>Seizures</b> | <b>Rash or Hives</b>   | <b>Fainting</b>  | <b>High or Low Cholesterol</b>    |
| <b>Difficulty Breathing</b> | <b>Broken Bones</b>     | <b>Diabetes</b> | <b>Hospitalization</b> | <b>Allergies</b> | <b>Severe Headaches</b>           |
| <b>Skin Conditions</b>      | <b>Concussion</b>       | <b>Numbness</b> | <b>Joint Pain</b>      | <b>Surgery</b>   | <b>Any other Conditions</b>       |

**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:

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

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

May this individual continue to train and participate in the 21-22 We ROCK program? **Yes No**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (print): \_\_\_\_\_ Stamp: \_\_\_\_\_