WeROCK – We Run Our Community's Kids
24-25 PHYSICAL CLEARANCE FORM

Name: _____ Grade in 2024/2025:____ 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**
Problems with vision	____	____
Eyeglasses	____	____
Contacts	____	____
Problems with hearing	____	____
Hearing Aid	____	____
Blacking out or fainting	____	____
Unconsciousness	____	____
Convulsions	____	____
Seizures	____	____
Heart Problems	____	____
Rheumatic fever	____	____
Bleeding Disorders	____	____
Blood Sugar Problems	____	____
Hypoglycemia	____	____
Diabetes	____	____
Allergies – type: _____	____	____
Bee or insect stings	____	____
Hospitalizations	____	____

	Yes	**No**
Surgeries	____	____
Dental Problems	____	____
Braces	____	____
False Teeth	____	____
Painful Joints	____	____
Broken Bones	____	____
Body Part:_____		____
Knee or ankle problems	____	____
Require support/brace	____	____
Need for medication	____	____
Name:_____		____
Menstruation Problems	____	____
Hernias	____	____
Asthma	____	____

OTHER HEALTH ASPECTS THE DOCTOR & WEROCK SHOULD BE AWARE OF: _____

_____ ____

_____ ____

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: _____ ORTHOPEDIC:_____

EARS:_____ LYMPH:_____ GLANDS: _____ HERNIA SKIN:_____

TEETH:_____ THYROID:_____ POSTURE:_____ OTHER:_____

BRACES:_____ HEART: _____ MUSCLE TONE:_____

NOSE: _____ LUNGS:_____ REFLEXES:_____

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****