DUBLIN COFFMAN MARCHING BAND
BAND CAMP 2019
MEDICAL FORMS CHECKLIST

THE FOLLOWING FORMS ARE DUE THE FIRST DAY OF JULY 4TH CAMP -- JULY 1, 2019

BAND DIRECTORS WILL NOT ACCEPT THE FORMS UNTIL THIS DATE. PLEASE KEEP FORMS UNTIL THE DATE REQUESTED.

1. _____ **District-Sponsored Overnight Trips
   Medical Permission Form (DCS Form 2340C F1)
   Parent signature required and MUST BE NOTARIZED
   Physician signature required for those bringing prescription medications to camp.
   Please Notice it asks for copy of Immunization Record for TB

2. _____ Attach a copy (front and back) of your insurance card to the above mentioned DCS Form 2340C F1

3. _____ Asthma Action Plan and Orders
   (DCS Form 5330A A F1).
   Parent and Physician signatures are required.
   Return this form only if it applies to your child

4. _____ Allergy and Anaphylaxis Emergency Orders and Action Plan
   (DCS Form 5330A E F1).
   Authorization can be found on second page. (small type)
   Parent and Physician signatures are required.
   Return this form only if it applies to your child

5. _____ *The following is NOT REQUIRED but recommended especially for students with medical concerns.*
   Ohio High School Athletic Association Participation
   Physical Examination Form Physician signature is required.

6. _____ **Responsibility Contract for Overnight Trips
   (DCS Form 2340C F3)
   **Student and Parent Signature required and MUST BE NOTARIZED

Dublin City School District

Program
2340C F3
Revised 2/17/17

Responsibility Contract for Overnight Trips

- Student is to read and complete this form.
- Parent/custodian/guardian is to read and complete this form.
- The completed form is to be notarized and returned to the staff member in charge of the trip, submitted to the building principal, and left in the file in the building office.

It is a privilege for you to participate in the District-sponsored trip to **Jackson, OH and Indianapolis, IN**. Because this trip is part of the District's educational program, it is imperative that you adhere to the Code of Conduct for overnight trips as well as the applicable provisions of the general Code of Conduct/Student Discipline Code. You must remember that from the time of departure to your arrival home, you are the responsibility of the District.

I agree:

1. to refrain at all times from the consumption of alcoholic beverages and/or drugs, except parent or prescriber approved medications.
2. to sleep in my assigned room and not entertain members of the opposite sex in my room, unless my room door is fully opened and an adult chaperone is notified and/or present.
3. to keep my assigned chaperone advised of my whereabouts at all times.
4. to attend all mandatory activities and meal functions.
5. to adhere to all established curfews.
6. to conduct myself in such a manner as to bring pride to my family, my school, my community, and myself.
7. to adhere to any established dress code.
8. to comply, throughout the trip, with any and all instructions directed to me and/or the group by a chaperone or staff member.

If a problem arises that is serious enough in nature to warrant the below-named student's removal from the travel group, we (the student and parent/guardian) agree to bear any additional costs to return the student home. NOTE: the accompanying professional staff member will make this removal decision after a student has been provided the opportunity to respond to any allegations. The student may also be subjected to discipline upon his/her return home in accordance with general District policies.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The State of Ohio, County of _____.

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____
Notary Public

My commission expires: _____

Original: Building Copies: Trip Leader, Parent/Guardian

Dublin City School District

District-Sponsored Overnight Trip Medical Permission Form

- Upon central office approval of a district-sponsored overnight trip, the teacher in charge should distribute this form to all participating students.
- Parent/guardian is to read and complete this form, **have it notarized**, and return it to the teacher in charge of the trip. **Incomplete or non-returned forms shall result in the student being excluded from participation.**
- The teacher in charge of the trip shall take all completed forms on the trip for medical emergencies.
- All requests for chaperones to administer any medication requires an Ohio health care prescriber's signature.

Student's name: _____ Sex: _____ Birthdate: _____

Home address: _____ City: _____ Zip: _____

Mother/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

Father/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

EMERGENCY NUMBERS (if parent/guardian cannot be reached):

1. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

2. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

Student's health care provider: _____ Phone: _____

Medical insurance company: _____ Group No.: _____

Insurance company address: _____

Name of policy holder: _____ Identification/Policy No.: _____

If you have insurance, please attach a copy of the front and back of your insurance card to this form.

GENERAL HEALTH CARE INFORMATION

Please provide a copy of most current immunization record.

If your child was recently hospitalized, has a fracture or needs specific medical care, please attach written health care provider instructions to this form.

Please check all that apply to your child.

☐ Animal Allergies	☐ Poison Ivy allergy	☐ Activity restrictions	☐ Heart problem
☐ Bee/Insect Allergies	☐ Bleeding problem	☐ Dietary restrictions	☐ Migraines
☐ Drug Allergies	☐ Mobility concerns	☐ Asthma	☐ Glasses/contacts
☐ Environmental Allergies	☐ Sleep walking	☐ Seizures	☐ Ear infections/aids
☐ Food Allergies	☐ Bed wetting	☐ Diabetes	☐ Other _____

Please describe any medical condition including severity and treatment. _____

_____

Food Restrictions/Allergies: _____

District-Sponsored Overnight Trip
Medical Permission Form

Student's name: _____

MEDICATION

- Students in middle and high school may self-carry their nonprescription and/or emergency medication.
- Parent/guardian is responsible for supplying all medication in its original container, labeled with student's name, and should only include the total number of doses needed for the duration of the trip.
- All medication to be administered by a chaperone will require signed approval by a healthcare prescriber.
- For medication administration procedure, see Board Policy 5330, "Use of Medications".
- Please follow the direction of the trip coordinator for medication drop off procedure.
- Section "A" (Chaperone Administered Medication & Emergency Medication) is to be completed and signed by an Ohio licensed healthcare prescriber.
- Section "B" (Self-Carry Medication [Nonprescription Medication]) is to be completed by the parent/guardian.
- Section "C" is the Parent/Guardian Authorization, Emergency Consent, and Signature.

SECTION A – CHAPERONE ADMINISTERED MEDICATION & EMERGENCY MEDICATION (prescriber to complete)

Medication	Dose/Route	Time(s) to be given	Side Effects

Please list any special storage or considerations: _____

If medication is an inhaler, EpiPen, or medication and supplies for diabetic management, may the student self-carry? Yes ☐ No ☐

As a licensed health care prescriber in the state of Ohio, and at the request of this student's parent/guardian, I direct that the above medication(s) be administered as indicated above.

Prescriber's printed name and title: _____

Prescriber's signature: _____ Phone: _____ Date: _____

SECTION B – SELF-CARRY MEDICATION (Nonprescription Medication) (parent/guardian to complete)

Medication	Dose/Route	Time(s) to be given	Side Effects

SECTION C – PARENT/GUARDIAN AUTHORIZATION, EMERGENCY CONSENT, AND SIGNATURE

PARENT AUTHORIZATION AND EMERGENCY CONSENT

The information on this form is correct and complete to the best of my knowledge, and my child has my permission to participate in this event, with restrictions as noted. I understand and consent to the sharing of this information with all appropriate personnel who will be supervising my child for the duration of this trip or who may be responsible for the welfare of my child.

In the event I or another legal guardian cannot be reached in a medical or dental emergency, I consent for a school staff member to accompany my child to a medical facility. I authorize emergency medical or dental treatment by a licensed physician or dentist.

This authorization does not cover major surgeries or treatments unless the medical opinions of two other licensed physicians or dentists concur in the necessity and urgency for such surgery/treatments BEFORE they are performed.

NOTARY WITNESS TO PARENT/GUARDIAN SIGNATURE

Parent/guardian signature _____ Date _____

State of Ohio, County of _____

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____

Notary Public

My commission expires _____

Only If Needed

Dublin City School District

Allergy and Anaphylaxis Emergency Orders and Action Plan

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____
street city state zip

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS

Short of breath, wheezing, repetitive cough

Pale, blue, faint, weak pulse, dizzy

Tight, hoarse, trouble breathing/ swallowing

Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Adverse reaction to be reported to prescriber: _____

_____

Adverse reactions that may occur to another child for whom the epinephrine is not prescribed, should such a child receive a dose of the medication:

_____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

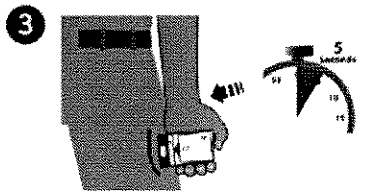
Start Date: _____ End Date: _____

Parent/Guardian authorization signature Date Physician/HCP authorization signature Date

Allergy and Anaphylaxis Emergency Orders and Action Plan (cont.)

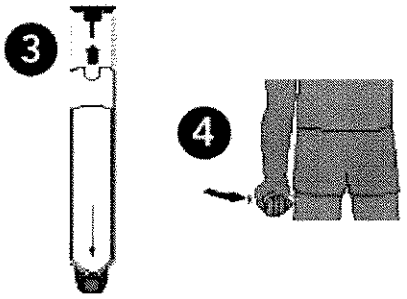
Student's name: _____

AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



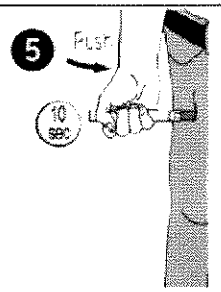
1. Remove Auvi-Q® from the outer case.
2. Pull off the red safety guard.
3. Place black end of Auvi-Q® against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

EPIPEN®, EPIPEN JR®, AUTHORIZED GENERIC OF EPIPEN®, or USP AUTO-INJECTOR, MYLAN DIRECTIONS



1. Remove the EpiPen®, EpiPen Jr®, authorized generic of EpiPen®, USP auto-injector, Mylan from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES DIRECTIONS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION

SELF-CARRY AUTHORIZATION

[ ] Physician acknowledgement of training in the proper use of auto-injector
[ ] Self-carry (student is capable of possession and proper use of auto-injector)

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS – CALL 911

Rescue Squad: _____
Doctor: _____ Phone: _____
Parent/Guardian: _____ Phone: _____

OTHER EMERGENCY CONTACTS

Name/Relationship: _____
Phone: _____
Name/Relationship: _____
Phone: _____

Physician signature _____ Date _____

Parent/Guardian authorization signature _____ Date _____

Only If Needed

Dublin City School District

Asthma Action Plan and Orders

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____ School/Grade: _____
street city state zip

I. Healthcare Provider's Section

Severity classification ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent
Asthma triggers ☐ none ☐ animals ☐ cold air ☐ exercise ☐ pollen ☐ respiratory illness
☐ smoke, chemicals, strong odors ☐ other (food, emotions, insects, etc.) _____
Peak flow meter personal best _____

Quick relief medication orders: (check the appropriate quick relief med(s)) ☐ Uses inhaler with spacer
☐ Albuterol ____ puffs (Proair®, Ventolin HFA®, Proventil®) as needed every ____ hours for cough/wheeze
☐ Levalbuterol ____ puffs (Xopenex®) as needed every ____ hours for cough/wheeze
☐ Other _____ Epi auto-injector ☐ 0.3 mg ☐ Jr.0.15 mg

SIDE EFFECTS of medication(s): _____

Green Zone: Doing Well
Symptoms: Breathing is good – No cough or wheeze
Peak flow meter _____ (more than 80% of personal best)
Physical activity: ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when the child fees he/she needs it

Yellow Zone: Caution – DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Problems breathing – Cough, wheeze, or chest tight
Peak flow meter _____ to _____ (between 50% and 79% of personal best)

- If student is using quick relief inhaler > 2 times a week or requires frequent observation by school staff → **Notify** parents + school nurse.
- If student is coughing, wheezing and having difficulty breathing:
  ☐ Give ____ puffs of quick relief inhaler. May repeat in ____ minutes. → **Notify** parents and school nurse if repeated.
- If **NO** improvement after repeated dose, call 911 – see below.

Red Zone: CALL 911 and DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Difficulty talking – Shortness of breath – Getting worse instead of better –
Blue appearance (lips/nails) – Medicine is not helping
Peak flow meter _____ (less than 50% of personal best)
☐ Give ____ puffs quick relief inhaler or nebulizer treatment and **notify** parents and school nurse.
☐ This student needs Epi auto-injector for severe asthma attacks and
☐ can carry and self-administer Epi auto-injector ☐ needs help giving the Epi auto-injector ☐ other _____

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Special storage instructions: _____

Start date: _____ End date: _____

Healthcare provider

Name _____ Date _____ Phone _____ Signature _____

Student's name: _____ Birthdate: _____

II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities

A new Asthma Action Plan and Orders form must be submitted each school year.

I understand that if any changes are needed on this Asthma Action Plan and Orders form, it is the parent's responsibility to contact the school nurse and submit a new form.

I understand that my child may be eligible for Section 504 plan.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Parent/Guardian signature Date

Home address Daytime phone

Only If Needed

Ohio High School Athletic Association
Preparticipation Physical Evaluation

DATE OF EXAM:_____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade_____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician_____

In case of emergency, contact: *Name* _____ *Relationship* _____

Phone (H) _____ *(W)* _____ *(Cell)* _____ *(Cell)* _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

		Yes	No
1.	Has a doctor ever denied or restricted you participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Do you think you are in good health?	☐	☐
6.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Does your heart race or skip beats during exercise?	☐	☐
10.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection		
11.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12.	Has anyone in your family died for no apparent reason?	☐	☐
13.	Does anyone in your family have a heart problem?	☐	☐
14.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15.	Does anyone in your family have Marfan syndrome?	☐	☐
16.	Have you ever spent the night in a hospital?	☐	☐
17.	Have you ever had surgery?	☐	☐
18.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
19.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
20.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand / Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / Toes

21.	Have you ever had a stress fracture?	☐	☐
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23.	Do you regularly use a brace or assistive device?	☐	☐
24.	Has a doctor ever told you that you have asthma or allergies?	☐	☐

		Yes	No
25.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26.	Is there anyone in your family who has asthma?	☐	☐
27.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
28.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31.	Have you had a herpes skin infection?	☐	☐
32.	Have you ever had a head injury or concussion?	☐	☐
33.	Have you been hit in the head and been confused or lost your memory?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Do you have headaches with exercise?	☐	☐
36.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40.	Have you had any problems with your eyes or vision?	☐	☐
41.	Do you wear glasses or contact lenses?	☐	☐
42.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43.	Are you happy with your weight?	☐	☐
44.	Are you trying to gain or lose weight?	☐	☐
45.	Has anyone recommended you change your weight or eating habits?	☐	☐
46.	Do you limit or carefully control what you eat?	☐	☐
47.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

48.	Have you ever had a menstrual period?	☐	☐
49.	How old were you when you had your first menstrual period?	_____	
50.	How many periods have you had in the last 12 months?	_____	

Explain "Yes" Answers Here: (Attach additional sheets as needed)

_____

_____

_____

_____

_____

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Signature: _____ Date: _____

Athlete — Parent or Guardian (If athlete is under 18)

The student has family insurance ☐ Yes ☐ No; If yes, family insurance company name and policy number: _____

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 03/06

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name_____ Birth Date_____

Height_____ Weight_____ % Body Fat (optional)_____ Pulse_____ BP_____/_____, _____/_____, _____/_____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: _____

☐ Not cleared for: ☐ All Sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Name of Physician: (print/type/stamp) _____ (M.D., D.O., D.C.) Date: _____

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Address: _____ Phone: _____

Signature of Physician: _____