RIPON ATHLETIC CLEARANCE

School Year
2024-2025

Last Name:_____ Grade:_____

First Name:_____ Age:_____ D/O/B:_____

Address:_____

Parent's Name:_____ Contact #:_____

Parents email address:_____
Have you attended any other high school? Yes____ No____
If you answered yes please list the name of the school:_____

****Must have Athletic Clearance completed to participate in Summer Workouts for all sports.**

This medical history and exam is only intended to determine ability to participate in sports and is not a substitute for regular exams by your physician – Please circle in all answers before going to the Doctor

Have you ever had any of the following (please circle Y or N):

YE S	NO		YE S	NO	
Y	N	1. Head Injury	Y	N	12. Anemia, leukemia or other blood disorder
Y	N	2. Back or neck problems or curvature of the spine	Y	N	13. Diabetes
Y	N	3. Broken Bones, dislocations, or amputations	Y	N	14. Hernia, kidney problem, testicle problem
Y	N	4. Polio or problems with foot, knee, or other joints	Y	N	15. Enlarged spleen or liver
Y	N	5. Eye injury, eye surgery, eye disease	Y	N	16. Surgery other than tonsils
Y	N	6. Wear glasses, contacts, hearing aid or dentures	Y	N	17. Family history of sudden death
Y	N	7. Headaches-other than minor headaches	Y	N	18. Presently taking any medication (list below)
Y	N	8. Drug addiction, mental illness, nervous disorder	Y	N	19. Allergic to medicine, foods, bee stings, etc.
Y	N	9. Epilepsy, fits, fainting, or dizzy spells	Y	N	20. Do you have any ongoing medical problems
Y	N	10. Lung trouble, shortness of breath, asthma	Y	N	21. Do you know of any reason why you should not Participate in sports? _____
Y	N	11.Heart trouble, rheumatic fever	_____		Date of last tetanus immunization (Recommended every 3 years)

Current Medications _____

Physical good for one calendar year from date of exam **PHYSICIANS PHYSICAL EXAM**

Date:_____ B/P:_____ Sex: M or F Weight:_____ Height:_____

I have examined this student and have found him / her: (check one) ☐Fit for Sports ☐In need of further evaluation:

Reason:_____

Physician Signature_____

Place physician stamp here

Parent Signature to treat: _____

Date: _____

Revised:
3/13/24 rw

Take a photo with your Phone and then upload to HomeCampus.com