

RIPON ATHLETIC CLEARANCE

School Year 2022-2023

Check Your Sports:

*Check all that apply

FALL

- Football
- Volleyball
- Girls Golf
- Girls Tennis
- Cross Country

WINTER

- Boys Basketball
- Girls Basketball
- Boys Soccer
- Girls Soccer
- Wrestling

SPRING

- Baseball
- Boys Tennis
- Softball
- Boys Golf
- Swimming

Track & Field

- Swimming
- JROTC
- CHEER
- POWDERPUFF
- Boys Volleyball

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: _____

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

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

<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	
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 _____

Office Phone: _____ Physicians

Stamp: _____

Place physician stamp here

Parent Signature to treat: _____

Date: _____