PREPARTICIPATION ATHLETIC CLEARANCE ANNUAL UPDATE

Weight:_____ Blood pressure_____ Medications/Supplements:_____

Cardiovascular risk assessment ***SPORT:*** _____

YES	NO	**In the past year, have you had:**
		Chest pain or discomfort related to exertion/exercise/training?
		Fainting or nearly fainting related to exertion/exercise/training?
		Unusual or unexplained shortness of breath related to exertion/exercise/training?
		A family member die or become disabled from cardiovascular disease before age 50?
		A family member die unexpectedly and/or suddenly before age 50?

Other sudden death risks

YES	NO	**In the past year, have you had:**
		An allergic reaction severe enough to require hospital treatment?
		An injury to the chest (e.g., hitting the steering wheel in a car accident)?
		Treatment for asthma?
		A family member diagnosed with Marfan's Syndrome?

Risks related to sports participation

YES	NO	**In the past year, have you had:**
		Skull fracture, concussion, or loss of consciousness due to head injury?
		Heat exhaustion or heat stroke?
		Concerns regarding weight or eating?
		(Women only) Three or more months without a period?

Injury assessment

YES	NO	**In the past year, have you had:**
		Any neck or back injury?
		Broken bones or joint dislocations?
		An orthopedic visit at the request of the training room?
		Physical therapy?

Miscellaneous

YES	NO	**In the past year, have you had:**
		Surgery?
		To stay over night in the hospital?
		Any significant illness or injury?
		An illness or injury which prevented you from playing sports for 2 weeks or more? (If so, you must provide a clearance note from the treating health care provider before you will be cleared for participation.)
		Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? (Please let us know if you would like more information or to be tested for this.)

Explain "YES" answers here and GIVE DATES:

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____

PRINT NAME SIGNATURE PERM # DATE

Training Room Review: ☐ CLEARED Signature_____ Date_____

Student Health Review: ☐ CLEARED Signature_____ Date_____