

Primary Pediatric Medical Group, Inc.

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 Castro Valley, CA 94546
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Alameda Office
 1332 Park Street, Suite 200
 Alameda, CA 94501
 (510) 523-3123
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Clinician: _____

(Print)

<i>Patient/Parent: Please complete shaded section as it pertains to the patient being seen today.</i>	YES	NO	
			PRE-PARTICIPATION MEDICAL CLEARANCE FORM
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	Name _____ DOB _____
2) Do you have an ongoing medical condition (like diabetes or asthma?)	<input type="checkbox"/>	<input type="checkbox"/>	Height _____ Weight _____ BMI%ile _____
3) Are you currently taking any prescription or over-the-counter medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure _____
4) Do you have allergies to medicines, foods, insects or pollens?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
5) Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Vision <input type="checkbox"/> Normal <input type="checkbox"/> Wears Glasses/Contact Lenses
6) Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abnormal: _____
7) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No Allergies <input type="checkbox"/> Allergy to: _____
8) Has a doctor ever ordered a test for your heart (EKG or echocardiogram?)	<input type="checkbox"/>	<input type="checkbox"/>	Medications: _____
9) Has anyone in your family died suddenly or for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10) Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	I certify that I have examined this patient and reviewed his/her medical history on: _____
11) Has any family member or relative died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	This patient is:
12) Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cleared for participation in ALL ACTIVITIES (School, Camp, Sports, Travel)
13) Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cleared with the following RESTRICTIONS:
14) Have you ever used an inhaler or needed asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15) Were you born without or are you missing a kidney, eye or testicle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16) Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17) Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations:
18) Have you ever been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Up to Date (see attached)
19) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Up to Date- Details: _____
20) Are you taking any medications or supplements to help you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	_____
21) Are you taking any medications or supplements to increase your strength or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Explain "Yes" answers here: _____			Physician's Signature _____ Date _____
_____			This form is valid from the date above to 375 days forward
_____			I hereby state that to the best of my knowledge, my answers to the questions on the left are complete and correct.
_____			Signature of Athlete _____ Date _____
_____			Signature of Parent or Guardian _____ Date _____
