

B.M.C. Durfee High School
Medical History Questionnaire

Please print all information

Name _____ Sport(s) _____ Date of Birth _____ Age _____ YOG _____

Address _____ Home Phone # _____ Parent's Work # _____

Emergency Contact Person _____ Emergency Contact # _____ Family Physician _____

- YES NO Do you have any drug allergies? If yes, please list: _____
- YES NO Are you allergic to bees or other insects? If yes, do you need medication? _____
- YES NO Do you have any other allergies? If yes, please explain: _____
- YES NO Have you ever fainted while exercising? If yes, please explain: _____
- YES NO Do you have any type of seizure disorder? If yes, please list medications: _____
- YES NO Have you ever had a heart murmur or any other type of heart disorder? If yes, please explain: _____
- YES NO Have you ever experienced shortness of breath or chest pain during activity? Please explain: _____
- YES NO Are you missing any paired organs (eye, lung, kidney, testicle, ovary, arm, leg)? If yes, please explain: _____
- YES NO Do you wear contact lenses to play? Hard or soft? _____
- YES NO Do you wear glasses to play? Plastic or glass lenses? _____
- YES NO Have you ever had Pneumonia? If yes, when? _____
- YES NO Do you have asthma? If yes, please list medications and directions for use: _____
- YES NO Are you currently taking any medication? If yes, please list and explain: _____
- YES NO Do you require any special taping or brace for sports? If yes, please explain: _____
- YES NO Do you have diabetes? If yes, are you insulin dependent? _____ Please list medications: _____
- YES NO Have you ever had a head injury? _____ If yes, were you unconscious for any length of time? _____
How long? _____ Were you hospitalized? _____ Please explain: _____
- YES NO Have you ever injured your neck? When? _____ How? _____
- YES NO Have you ever injured your shoulder? Which one? _____ How? _____
- YES NO Have you ever injured your elbow? Which one? _____ How? _____
- YES NO Have you ever injured your wrist? Which one? _____ How? _____
- YES NO Have you ever injured your hand or fingers? Which one(s)? _____ How? _____
- YES NO Have you ever injured your ribs or stomach? How? _____ When? _____
- YES NO Have you ever injured your back? How? _____ When? _____
- YES NO Have you ever injured your hip or groin? Which one? _____ How? _____
- YES NO Have you ever injured your knee? Which one? _____ How? _____
- YES NO Have you ever injured your ankle or foot? Which one? _____ How? _____
- YES NO Have you ever broken any bones? If yes, please explain: _____
- YES NO Have you ever had surgery? If yes, for what? _____
- YES NO Do you have high blood pressure? If yes, are you currently taking medication? _____ Please list: _____
- YES NO Are you currently under a physician's care? If yes, please explain: _____
- YES NO Do you have any other medical condition(s) that has not been listed? Please explain: _____

_____ Yes, I give my permission for my child to be examined by the school physician.

_____ No, I do not wish for my child to be examined by the school physician.

Parent's Signature: _____ Date _____

Athlete's Signature: _____ Date _____

B.M.C. Durfee High School
Medical Clearance Form

Name _____ Sport(s) _____ YOG _____

Address _____ Date of Birth/Age _____ Phone # _____

Height _____ Weight _____ Blood Pressure _____

Medical	Normal	Abnormal Findings	Comments
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Physician's Name (Please Print) _____ Date _____

Address _____ Phone # _____