

SPORTS PARTICIPATION

Name: _____ Birthdate: _____ Date: _____

Please answer the following questions by circling the appropriate answer, and for any answer circled "yes", please explain the circumstances in the margin.

1. *Have you been told you could not participate in a sport in the last two years?* YES NO
2. *Have you even been unconscious or lost memory from a blow to your head?* YES NO
3. *Have you had a fracture or dislocation in the last two years?* YES NO
4. *Have you had a knee or ankle sprain in the last two years?* YES NO
5. *Have you had any other injuries?* YES NO
6. *Are you under a physician's care now for a health problem?* YES NO
7. *Do you take any kind of medication every day?* YES NO
8. *Do you have any allergies?* YES NO
9. *Have you been in the hospital for an operation or to stay overnight?* YES NO
10. *Do you have any worries about your health or other questions you would like to discuss with a physician?* YES NO
11. *Have you ever felt faint or fainted during or after exercise?* YES NO
12. *Has any family member or relative died of heart problems or of sudden death before age 50?* YES NO
13. *Does anyone in your family have Marfan Syndrome?* YES NO
14. *Do you cough, wheeze, or have difficulty breathing during or after exercise?* YES NO
15. *Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?* YES NO
16. *Have you had infectious mononucleosis (mono) within the last month?* YES NO
17. *Have you ever had a seizure?* YES NO
18. *Do you wear protective eyewear, such as goggles or a face shield?* YES NO

Well Exam – Sports Participation Clearance Form

NOTE: How often a clearance form is needed to play sports, is determined by your school. This clearance form is the only Sports Participation Clearance Form supported by the Vermont Principals' Association, the Vermont Departments of Health and Education, and the Vermont Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. The American Academy of Pediatrics Council on Sports Medicine and Fitness developed the research based screening activities done during a Well Exam, to determine sports readiness.

Student's Name _____

Age _____ Date of Birth _____ Grade _____

This Athlete is:

- Cleared without restriction
- Cleared, **with restrictions:**

- Not cleared for: All sports
- Certain sports _____

Reason: _____

Relevant Medical Information For Coaches and Athletic Department:

Allergies: _____ EpiPen Necessary: Yes No

Asthma: Yes No Emergency Medications: _____

Diabetes: Yes No Emergency Medications: _____

Seizure Disorder: Yes No Emergency Medications: _____

Well Exam using ICD -9-CMcode:

- | | | |
|---|---|---|
| <input type="checkbox"/> 99383 or 99393 | <input type="checkbox"/> 99384 or 99394 | <input type="checkbox"/> 99385 or 99395 |
| <i>5-11 years</i> | <i>12-17 years</i> | <i>18-39 years</i> |

NOTE: Clearance form is not valid unless one of these Well Exam codes is checked by provider

Comments: _____

Name of Provider (print/type): _____ Provider Phone #: _____

Signature of Provider: _____ Date of Exam: _____

Suggestion for Athletic Department: Please make copy for School Nurse's Office records