The following should be completed by the student athlete with help from the parent(s) only as necessary. The following questions are to be answered yes or no. Please check the appropriate box. Comment on all "yes" answers. (Include dates if possible). For any significant medical or orthopedic problems, please obtain medical records. This may limit delays in your clearance to participate.

Has anyone in your immediate family ever had:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (high blood sugar)</td>
<td></td>
</tr>
<tr>
<td>High blood pressure, high cholesterol</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Convulsions (seizures) or epilepsy</td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS

Have you ever had or do you now have:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain with or after exercise</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
</tr>
<tr>
<td>Wheezing/cough with exercise, or asthma</td>
<td></td>
</tr>
<tr>
<td>Heart murmur</td>
<td></td>
</tr>
<tr>
<td>History of one kidney or non-functioning kidney</td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS

Have you ever:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>Had convulsions (seizures) or epilepsy</td>
<td></td>
</tr>
<tr>
<td>Had a &quot;Stinger&quot;, &quot;burner&quot;, or &quot;pinched nerve&quot;</td>
<td></td>
</tr>
<tr>
<td>Had heat exhaustion or intolerance in sports?</td>
<td></td>
</tr>
<tr>
<td>Had infectious mononucleosis? If yes, + blood test? Y / N</td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS

For the following questions, please provide detailed information (use accessory sheet of paper if necessary), include medical records, and also state the amount of time loss related to each injury/condition.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been hospitalized for a musculoskeletal problem or had surgery</td>
<td></td>
</tr>
<tr>
<td>Broken a bone</td>
<td></td>
</tr>
<tr>
<td>Had a muscle injury</td>
<td></td>
</tr>
<tr>
<td>Had a knee injury? R ( ) L ( ) Ligament ( ) Meniscus ( ) Other ( )</td>
<td></td>
</tr>
<tr>
<td>If yes, did you have surgery? Result:</td>
<td></td>
</tr>
<tr>
<td>Had a shoulder injury? R ( ) L ( )</td>
<td></td>
</tr>
<tr>
<td>If yes, did you have surgery? Result:</td>
<td></td>
</tr>
<tr>
<td>Had a back injury?</td>
<td></td>
</tr>
<tr>
<td>If yes, did you have surgery? Result:</td>
<td></td>
</tr>
<tr>
<td>Had any other joint injuries? Check appropriate box(es): Hip ( ) Elbow ( ) Wrist ( ) Foot ( ) Other:</td>
<td></td>
</tr>
<tr>
<td>Had an MRI, CT scan, bone scan or other special study? If so, please specify when and why:</td>
<td></td>
</tr>
<tr>
<td>Had a stress fracture? If yes, state location, method of diagnosis, and time loss</td>
<td></td>
</tr>
<tr>
<td>Do you currently wear prescribed orthotics? If so, why?</td>
<td></td>
</tr>
<tr>
<td>If you have had a musculoskeletal injury, have you recovered fully from this injury and returned to full participation?</td>
<td></td>
</tr>
</tbody>
</table>

For any significant medical or orthopedic problems, please obtain medical records.
Have you had or do you now have:

YES  NO
( ) ( ) Hearing loss or perforated eardrum
( ) ( ) Headaches or migraines
( ) ( ) Hernia
( ) ( ) Loss of function or absence of testicle (males), ovary
( ) ( ) Dental plate, impaired vision, wear glasses/contacts: __________________________
( ) ( ) ( ) Other paired organ (eyes, etc):

Have you in the past, or do you currently use, or have concerns about:

YES  NO
( ) ( ) Cigarettes, chewing tobacco, or marijuana
( ) ( ) Recreational drugs or steroids
( ) ( ) Have little interest or pleasure in doing things
( ) ( ) Wear a seat belt 90% of the time
( ) ( ) Wear a bicycle/motorcycle helmet
( ) ( ) Understand and regularly perform a self-breast exam or self-testicular exam
( ) ( ) Practice safe sex
( ) ( ) Have a history of > 2 sexual partners in the last 6 months
( ) ( ) Have a history of any sexually transmitted disease
( ) ( ) Have any additional concerns or questions

Have you in the past or do you currently use alcohol? YES  NO
Have you in the past or are you currently being treated for an alcohol problem? YES  NO
If you drink alcohol, answer the following questions, selecting the option that comes closest to your answer:

How often do you have an alcoholic drink? Never Monthly 2-4 X / mo 2-3 X / wk 4 or > / week
How many alcoholic drinks do you have on a typical day? 0, 1, or 2 3 to 5 6 to 8 10 or more
How often do you have 4 or more drinks on 1 occasion? Never < monthly Monthly Weekly Daily or almost daily
How often in the last year have you found you are unable to stop drinking once you’ve started?
Never < monthly Monthly Weekly Daily or almost daily
How often in the last year have you failed to do what was normally expected of you because of drinking?
Never < monthly Monthly Weekly Daily or almost daily
How often in the last year have you needed a drink in the morning to get yourself going after a heavy night of drinking?
Never < monthly Monthly Weekly Daily or almost daily
How often during the last year have you felt guilty or been remorseful after drinking?
Never < monthly Monthly Weekly Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?
Never < monthly Monthly Weekly Daily or almost daily
Have you or someone else been injured as a result of your drinking? No / Yes, but not in the last year Yes, in the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
No / Yes, but not in the last year __________________________________________ Yes, in the last year __________________________________________

Nutritional concerns:
What is your present weight? __________ Are you happy with your present weight? YES  NO If not, what is your desired weight? __________ How many meals do you eat each day? __________________________ Do you diet regularly? YES  NO
Do you avoid certain food groups (carbohydrates, protein, meat, fats, salt, other)? YES  NO Why? __________________________
Do you ever feel out of control of your eating patterns?
Have you tried to control your weight by: Excessive exercise? YES  NO Dieting/Fasting? YES  NO Vomiting? YES  NO Diet pills? YES  NO Laxatives? YES  NO Diuretics? YES  NO
Have you ever had an eating disorder?
Have you ever taken supplements to help you gain or lose weight or improve your performance? YES  NO
List any current medications: (include vitamins, List any allergies: (medications, animals, food, pollen) __________________________

Over the counter medications, supplements, and birth control pills) __________________________

I, ____________________________________ declare that all of the above information is true to the best of my knowledge.

(Print) __________________________ __________________________
(Signature) __________________________ Date:

(Print) __________________________ __________________________
(Signature of parent if < 18 yrs. Old) __________________________ Date:
PHYSICAL EXAMINATION  
(To be completed by Elon University Physician)

Blood pressure _______  Pulse _______  Height _______  Weight _______  BMI _______

Vision R 20/ _______ L 20/ _______ corrected Y / N  Pupil size: equal/unequal

Normal Abnormal Comments

YES  NO
( ) ( ) HEENT ____________________________
( ) ( ) Thyroid ____________________________
( ) ( ) Lymphatics ____________________________
( ) ( ) Cardiac ____________________________
( ) ( ) Lungs ____________________________
( ) ( ) Skin ____________________________
( ) ( ) Abdominal ____________________________
( ) ( ) Genitalia Hernia? If Yes, when ____________________________
( ) ( ) Musculoskeletal: ____________________________
( ) ( ) Neck ____________________________
( ) ( ) Shoulder ____________________________
( ) ( ) Elbow ____________________________
( ) ( ) Wrist/hand ____________________________
( ) ( ) Back Scoliosis? If Yes, when ____________________________
( ) ( ) Knee ____________________________
( ) ( ) Ankle, foot ____________________________
( ) ( ) Neurological ____________________________
Other: __________________________________________________________________

I certify that I have reviewed the history and examined the above athlete, and I recommend sports activity:

Clearance with no limitations: __________________________________________________________________

Clearance pending further evaluation or testing: __________________________________________________________________

Referral to: __________________________________________________________________prior to clearance.

Clearance with limitations: __________________________________________________________________

Disqualification from competition: __________________________________________________________________

Signature of Examining Physician __________________________________________________________________Date ________________