TRACK XPLOSION

HEALTH APPRAISAL FORM

Section I: To Be Completed By Licensed Medical Provider

ATHLETE INFORMATION

Athlete Name: _____ Date of Birth: _____

Gender: Male Female Age: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Pulse: _____bpm Blood Pressure: _____/_____

Vision: R 20/_____ L 20/_____ Corrected: Yes No Glasses: Yes No Contacts: Yes No

INDICATORS	NORMAL	ABNORMAL	ABNORMAL FINDINGS
Eyes			
Ears/Nose/Throat			
Mouth/Teeth			
Neck/Back/Spine			
Cardiovascular			
Chest/Lungs			
Abdomen			
Skin			
Genitalia-Hernia (male)			
Musculoskeletal: ROM, Strength, Stability			
• Neck			
• Spine (Scoliosis)			
• Shoulders			
• Arms/Hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
• Feet			
Neuromuscular			

Diabetes: Yes No	If yes, Insulin Dependent? Yes No	Non-Insulin Dependent? Yes No

Provide additional comments on abnormal findings: _____

_____

EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION

Physician Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner in the United States.

Physician's Signature: _____

Printed Name: _____ Date: _____

TRACK XPLOSION

HEALTH APPRAISAL FORM

Section II: To Be Completed By Parent/Guardian or Adult Athlete (18 years old or older)

ATHLETE INFORMATION

Athlete Name: _____

MEDICAL INFORMATION

List allergies, medications, and other pertinent health information:

Allergies: _____

Medications: _____

_____

Other Pertinent Health Information: _____

_____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Phone: _____(home) _____(cell) _____(work)

Relationship: _____

First Name: _____ Last Name: _____

Phone: _____(home) _____(cell) _____(work)

Relationship: _____

HEALTH INSURANCE INFORMATION

Policy Holder: First Name: _____ Last Name: _____

Provider: _____ Policy Number: _____

EMERGENCY MEDICAL AUTHORIZATION

In the event the need for emergency medical treatment arises and reasonable attempts to contact me or my Emergency Contact listed above have been unsuccessful, by my signature below I hereby give my consent for the administration of any emergency medical treatment deemed necessary by Dr._____, my preferred physician, whose phone number is _____; or in the event the preferred practitioner is not available I give my consent for the administration of emergency medical treatment by an emergency medical team, licensed physician or hospital chosen by the Club.

Facts concerning the child's or my, if adult athlete (18 years of age or older), medical history including allergies, medications, and any physical impairment to which a physician should be alerted are listed in the Medical Information Section above. I represent that the list above is current and accurate and includes all allergies. The undersigned further represents that the above named child or self, if adult athlete, is physically fit and physical impairments that will in any way effect their participation have been brought to the attention of the Track Xplosion Chairman in writing.

Parent/Guardian/Adult Athlete's Signature: _____

Printed Name: _____ Date: _____