COMET SPIRIT PHYSICAL EVALUATION FORM

The participant and/or legal guardian should complete this ENTIRE PAGE before the actual appointment for the Physical Evaluation. Your doctor will complete Pages 2 and 3. Please explain ALL "Yes" answers below.

Name _____ Sex_____Age_____Date of birth_____

Activities (Cheerleading/Power Dancers/Mascot)_____

Address_____Phone_____

Personal Physician _____Phone_____

In case of emergency, contact:

Name _____Relationship_____

Phone (H)_____Phone(W)_____Phone(C)_____

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had any skin infections?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles orvv a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Explain ALL "Yes" answers here:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Participant _____Signature of Parent/Guardian _____ Date _____

COMET SPIRIT-PHYSICAL EVALUATION FORM
DOCTOR'S CERTIFICATION

THIS FORM SHOULD BE COMPLETED BY YOUR DOCTOR
DURING THE PHYSICAL EVALUATION APPOINTMENT.

Name _____Date of Birth_____

Height_____Weight_____% Body Fat (optional)_____Pulse_____BP____ / ____ (____ / ____, ____/ ____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: _____
_____
_____

Name of physician (print/type)_____Date_____
Address_____Phone_____

Signature of physician _____, MD or DO

COMET SPIRIT PHYSICAL EVALUATION FORM
CLEARANCE FORM

THIS FORM SHOULD BE COMPLETED BY YOUR DOCTOR
DURING THE PHYSICAL EVALUATION APPOINTMENT.

Participant's Name_____

Sex_____Age_____Date of birth_____

☐ Cleared without restriction

☐ Cleared, with recommendations for furtherevaluation or treatmentfor:_____
_____
_____
_____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason:_____

Recommendations:_____
_____

EMERGENCY INFORMATION

Allergies _____

Other Information
_____

_____

Name of Physician (Please PRINT or TYPE)_____

Address _____

City, State, ZIP _____

Phone _____

Signature of physician _____, MD or DO

Date _____