# Pasadena Running Roses
## PHYSICAL FITNESS & MEDICAL HISTORY FORM

**Special Note:** This form must be presented to the track & field club for athlete participation. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.) Form must be dated as follows for season: SUMMER – after July 1st of previous year; FALL – after December 1st of previous year.

**Section I: FOR PARENT/GUARDIAN COMPLETION ONLY:**

Last: _____ First: _____ Middle: _____

Date of Birth: _____ ☐ Male ☐ Female

Sport: Track & Field

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**PARTICIPANT MEDICAL HISTORY** (Please check any that apply to participant)

| | | | |
|---|---|---|---|
| Prior injuries requiring medical attention | ☐ | Asthmatic requiring the use of an inhaler | ☐ |
| Past surgeries or scheduled surgeries | ☐ | Wear a brace or other medical support device | ☐ |
| Currently under medical care | ☐ | Have / had seizures | ☐ |
| Currently taking medications | ☐ | Previous concussions | ☐ |
| Current allergies (penicillin, bee stings, etc) | ☐ | Wear glasses or contact lenses | ☐ |
| Diabetic /require medication for diabetes | ☐ | Have physical limitation or medical conditions | ☐ |

If you checked any of the above, please provide an explanation in the following space:

_____

_____

**I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that is my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.**

Signed: _____ Date: _____

**Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A MEDICAL PROFESSIONAL**
(Please check the following if healthy or note otherwise):

Height: _____ Weight: _____

| | Normal | Abnormal Findings | | Normal | Abnormal Findings |
|---|---|---|---|---|---|
| Medical | | | Musculoskeletal | | |
| Appearance | ☐ | | Neck | ☐ | |
| Skin | ☐ | | Back | ☐ | |
| Eyes/Ears/Nose | ☐ | | Shoulder/arm | ☐ | |
| Throat/Oropharynx | ☐ | | Elbow/forearm | ☐ | |
| Lymph Nodes | ☐ | | Wrist/hand | ☐ | |
| Heart | ☐ | | Hip/thigh | ☐ | |
| Pulses | ☐ | | Knee | ☐ | |
| Lungs | ☐ | | leg/angle | ☐ | |
| Abdomen | ☐ | | Foot | ☐ | |
| Genitalia/Hernia | ☐ | | | | |

( ) Cleared ( ) Not Cleared Reason: _____

Name of Physician: _____ Date: _____

Signature of Physician: _____ Phone: _____