

ST. IGNATIUS COLLEGE PREPARATORY

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TICKET-TO-PLAY MEDICAL CLEARANCE FORM

Parents - Please upload and submit this completed form online through your
Family ID Athletic Registration Account at www.familyid.com

HARDCOPY FORMS WILL NOT BE ACCEPTED BY THE ATHLETIC DEPARTMENT!

Need help? Contact Head Athletic Trainer, Josh Pendleton at jpendleton@siprep.org

MEDICAL INFORMATION - STUDENT'S HISTORY (Please Print)

NAME _____ DOB ____/____/____ HEIGHT _____ WEIGHT _____
PULSE _____ BP _____ VISION: R20/____ L20/____ GLASSES or CONTACTS ____Y/N____ PUPILS _____

1. Chronic or recurrent illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	8. Has any family member had a heart attack at less than 35 years of age?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Heat exhaustion, heatstroke, or other problems with heat?	Yes <input type="checkbox"/> No <input type="checkbox"/>	9. Neck, back or head injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Hospitalization?	Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Concussion or loss of consciousness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Surgery other than removal of tonsils?	Yes <input type="checkbox"/> No <input type="checkbox"/>	11. Upper Extremity injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Missing organs (eye, kidney, testicle)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Lower Extremity injury?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Shortness of breath or chest pain during exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Any other pertinent family history?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Dizziness or fainting with exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>	14. Any ongoing medical condition (Asthma, diabetes, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>

Explain "Yes" answers here:

Doctor's Examination	Normal	Abnormal Findings	Musculoskeletal	Normal	Abnormal Findings
Appearance			Neck		
Eyes/ears/nose/throat			Back		
Hearing			Shoulder/Arm		
Lymph Nodes			Elbow/Forearm		
Heart			Wrist/Hand/Fingers		
Murmurs			Hips/Thighs		
Pulses			Knee		
Lungs			Leg/Ankle		
Abdomen			Foot/Toes		
Genitourinary Skin (males only)					

Explain "Abnormal Findings" answers here:

List prescribed medications: _____ Time & Dosage of Medications: _____

List drug allergies: _____ List food allergies: _____

☐ Cleared without restriction.

☐ Cleared with the following restrictions/recommendations:

Signature of Physician

_____/_____/_____
Mo. Day Year

Doctor Office Official Stamp

