

# 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](http://www.familyid.com)  
**HARDCOPY FORMS WILL NOT BE ACCEPTED BY THE ATHLETIC DEPARTMENT!**  
 Need help? Contact Head Athletic Trainer, Jason Dinius at [jdinius@siprep.org](mailto:jdinius@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