Rolling Thunder Special Needs Program, Inc.
Physical Examination Form

Athlete Name: _____ DOB: _____ Age: ____ M/F Grade: _____
Name of Parent/Guardian: _____ Phone :(___) _____ Cell :(___) _____
Address:_____
City State Zip Code
Diagnosis: _____ Date of Onset: _____
For Persons with Down Syndrome*
Cervical x-ray for Atlanto-Axial Instability: Positive/Negative Date of X-ray:_____
Tetanus Shot: Yes/No Date of last shot: _____
Seizure Type: _____ Controlled: Yes/No Date of last seizure: _____

Has the athlete had problems with/treatment for any of the following in the **PAST YEAR**: (please answer Y=Yes or N=No)

Eyes: _____	Ears: _____	Nose: _____	Throat: _____
Mouth/Teeth: _____	Heart: _____	Murmur: _____	Rheumatic fever: _____
Lungs: _____	Asthma: _____	Pneumonia: _____	Bronchitis: _____
Bones, Joints: _____	Fractures: _____	Dislocations: _____	Muscles, Nerves: _____
Seizures: _____	Diabetes: _____	Abdomen: _____	Head Injury/Concussion: _____
Blood Disorder: _____	Hernia: _____	Kidney, Bladder: _____	Allergies/allergic reactions: _____

If yes to any of the above, please explain: _____
_____
_____

Have there been any hospitalizations in the past year? Yes/No If yes, give date and explanation: _____
_____

I hereby state that, to the best of my knowledge and belief, my answers to the above questions are correct. I hereby give permission for _____ to participate in Rolling Thunder Special Needs Program running club. **In the event of an emergency** and I cannot be reached, I consent for _____ to receive medical treatment.

_____ _____ _____
Signature of athlete (if 18 or older) Signature of parent/guardian Date

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Contact Lenses/Orthodontic Appliance Permission slip

I hereby give permission for _____ to engage in all athletic activities while wearing his/her contact lenses and/or orthodontic appliance. I understand that these materials can be lost, crushed, or damaged during body contact activities and vigorous exercise. I recognize that it is my responsibility to replace any personal items damaged or lost.

_____ _____ _____
Signature of Athlete (if 18 or older) Signature of parent/guardian Date

Rolling Thunder Special Needs Program, Inc.
Physical Examination Form

Physician Section:

Athletes Name: _________________________ DOB: _____________ M/F Sport: Distance Running/Track and Field
Height: ______ Weight: ______ Urine: protein: _______ glucose: _______ BP: _______ P: _______
Hearing: R: ________ L: ________ Vision: R 20/___ L 20/___ -vision corrected Y/N
Allergies: ______________________ Reaction: ______________ mild_____ moderate____ severe____ anaphylactic____
Medications: ____
Specify current disease: _____ Asthma _____Diabetes Other____
List of immunizations given today: ____

	Normal	Abnormal
HEENT		
Teeth/mouth		
Lymph nodes		
Thyroid		
Abdomen		
Lungs		
Heart		
Genitourinary		
Hernia (males)		
Neurological assessment		
Skin		
Speech		
Nutrition		
Orthopedic assessment		
a. posture		
b. structure		
c. extremities		
d. curvature of spine		

Explanation of abnormalities: ____________________
____
____
____
____
____

Learning Disabilities: __________________________
____
____

Mental Impairments: ___________________________
____
____

Psychological Impairment: ______________________
____
____

Mobility: Independent Ambulation: Yes/No
Crutches: Yes/No
Braces: Yes/No
Wheelchair: Yes/No

Onset of menses (female):____________
Please indicate any special instructions or precautions: ____
____
____

**************************************MUST BE COMPLETED FOR SPORTS ELIGIBILITY**************************************

I hereby certify that I have reviewed the health history, preformed a comprehensive initial pre-participation physical evaluation on the above named athlete, and, on the basis of such evaluation and the athlete's health history, certify, except as specified above, the athlete is physically fit to participate in practices, road races, and/or contests in the sport consented to by the athlete and parent/guardian in the Rolling Thunder Special Needs Program, Inc. sports registration and release form and further certify that the athlete does not have any communicable illnesses or condition which would pose a danger to teammates and/or competitors.

____ CLEARED FOR SPORTS
____ NOT CLEARED REASON: ____

MD SIGNATURE: ________________________________ **DATE OF PHYSICAL:** ________________________
STAMP: