Moon Crescent Athletic Association Health
PHYSICAL FITNESS & MEDICAL HISTORY FORM

Forms must be filled out annually and submitted to the MCAA organization on or before the first day of practice. Forms dated after January 1 will be accepted for the current season. No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.)

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last _____First_____Middle_____

Address:_____ City:_____ State: _____Zip:_____

Telephone No:_____ Date of Birth: _____ Male____ Female ____

Name of Primary Medical Insurance Company:_____

Policy Number: _____ Membership Number:_____

Name of Primary Insured: _____

Does primary insured have Medicaid? Yes No Does primary insured have Medicare? Yes No

PARTICIPANT MEDICAL HISTORY

1. Are there any injuries requiring medical attention?	Yes	No
2. Are there any past surgeries or scheduled surgeries?	Yes	No
3. Is there any history of concussions and/or head injuries?	Yes	No
4. Is the participant currently under the care of a medical practitioner?	Yes	No
5. Is the participant currently taking any medications?	Yes	No
6. Does the participant have any allergies (penicillin, bee stings, etc)?	Yes	No
7. Does the participant have asthma/require the use of an inhaler?	Yes	No
8. Is the participant diabetic/require medication for diabetes?	Yes	No
9. Does the participant carry sickle cell trait/suffer from sickle cell disease?	Yes	No
10. Does the participant currently require medication?	Yes	No
11. Does/has the participant have/had seizures?	Yes	No
12. Does the participant wear glasses or contact lenses?	Yes	No
13. Does the participant wear a brace or other medical support device?	Yes	No
14. Does the participant have any other physical limitations or medical conditions?	Yes	No

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space and/or attach to this form:

_____
_____
_____
_____

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 it's 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.

Signature of Parent or Legal Guardian: _____Print Name_____
Relationship to Participant_____ Dated_____

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Section II Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name_____ Age_____
Grade Enrolled in _____ School_____
Sport(s)_____
Height_____ Weight_____ % Body Fat (optional) _____
Blood pressure_____/_____ Resting Pulse_____
If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.
Age 10-12: BP: >126/82, RP: >104; Age 13-15: BP: >136/86, RP >100; Age 16-25: BP: >142/92, RP >96.
Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐Heart murmur ☐Femoral pulses to exclude aortic coarctation ☐Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in:

- ☐ CLEARED
- ☐ CLEARED, with recommendation(s) for further evaluation or treatment for:
  _____
- ☐ NOT CLEARED for the following types of sports (please check those that apply):
  ☐COLLISION ☐CONTACT ☐NON-CONTACT ☐STRENUOUS
  ☐MODERATELY STRENUOUS ☐NON-STRENUOUS

Due to Recommendation(s)/Referral(s) AME's Name (print/type) License # AME's
Signature_____ MD, DO, PAC, CRNP, or SNP (circle one) Date of CIPPE ___/____/___