Athlete's Medical Questionnaire

2 pages

Name			Date
DOB	Age	Home Phone	Work Phone

Please read each question carefully and answer every question honestly:

Yes	No	1) Has a physician ever diagnosed you with a heart condition **and** indicated you should restrict your physical activity? if yes, explain:
Yes	No	2) When you perform physical activity, do you feel discomfort in your chest?
Yes	No	3) Have you experienced chest pain in the past year? if yes, explain:
Yes	No	4) Do you ever faint or get dizzy and lose your balance, or have anxiety attack(s)? if yes, explain:
Yes	No	5) Do you have an injury or orthopedic condition (such as a back, hip, or knee problem) that may worsen due to a change in your physical activity? If yes, explain:
Yes	No	6) Do you have any condition for which a physician is currently prescribing a medication? If yes, explain:
Yes	No	7) Are you pregnant?
Yes	No	8) Do you have insulin dependent diabetes?
Yes	No	9) Do you have allergies which may require emergency intervention (Anaphylaxis)? If yes, explain:
Yes	No	10) Do you know of any other reason you should not exercise or increase your physical activity? If yes, explain:

If your health changes so you then answer yes to any of the above questions, or your prescription medications change, you must resubmit the physician-signed Medical Clearance Form before participation will be granted.

Participant signature	Date

Medical Clearance Form

to be completed by your physician

Dear Doctor:

Your patient _____ _____ wishes to take part in an athletic program, *pole vault training and competition*, which may include progressive resistance training, flexibility exercises, muscular strength and endurance training, acrobatic and gymnastic type physicality; increasing in duration and intensity over time. By completing this form, you are not assuming any responsibility for our athletic program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize _____ _____ to release to ____*Rocket Man Pole Vault, LLC*_____ , health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature, and immediately upon prescription changes. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Athlete's signature	Date
Athlete's Initials	*If my health changes so I then answer yes to any of the above questions, or my prescription medications change, I understand it is my sole responsibility to resubmit this physician-signed Medical Clearance Form before further participation in Rocket Man Pole Vault, LLC activities will be granted.*

Physician's Recommendations

	I am not aware of any contraindications toward participation in a fitness program.
	I believe the applicant can participate, but urge caution because:
	The applicant should not engage in the following activities:
	I recommend the applicant **not** participate in the above athletic program.
	**The applicant's medications and/or conditions have changed since this form was last submitted on _____, thus requiring re-evaluation. The physician's new recommendations are:* (date)

Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip