

I Can Do It, You Can Do It
Consent to Participate and Medical Release Form

Instructions

You should complete pages 1 and 2 of this form. When you have completed the first two pages (including a description of the physical activities you want to do in the program), you should take the form to your primary care provider and have him or her complete the third page of the form - the "Pre-Participation Medical Evaluation. On page four, he or she will indicate whether you can participate in the types of physical activities you have proposed and any limitations on your physical activity during the program. He or she will sign the form. You or your parent or guardian should also sign the form on the last page. If you are under the age of eighteen, your parents must sign. If you are 18 or older, you may sign the form. Take the completed form back to your Agency Coordinator.

Participant's Name: _____

Date of Birth: _____

Brief description of physical activities you wish to do during the "I Can Do It, You Can Do It" Program:

What medications are you taking? _____

Do you have any allergies to medication or foods? _____

Do you have any known Medical problems? _____

Pre-Participation Medical History Evaluation

Explain all "YES" answers on reverse side

	YES	NO
1. Are you under a physician's care for any reason now?	_____	_____
Have you ever been hospitalized?	_____	_____
Have you ever had surgery (i.e. tonsillectomy, arthroscopy, etc.)?	_____	_____
Are you missing any organs?	_____	_____
2. Are you presently taking any medications or pills?	_____	_____
3. Do you have any allergies (hay fever, hives, eczema, medicines, stinging insects, etc.)?	_____	_____
4. Do you have asthma or do you have trouble breathing or cough during or after activity?	_____	_____
5. Have you ever passed out during or after exercise?	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____
Do you tire more quickly than your friends during exercise?	_____	_____
Have you ever had high blood pressure?	_____	_____
Have you ever been told that you have a heart murmur?	_____	_____
Have you ever had racing of you heart or skipped beats?	_____	_____
Has anyone in your family experiences or died of heart problems before age 50?	_____	_____
6. Do you have, or have you had in the last six months, skin rashes?	_____	_____
7. Have you had a head injury?	_____	_____
Have you ever been knocked out unconscious?	_____	_____
Have you ever had a memory loss from any cause?	_____	_____
Have you ever had a seizure?	_____	_____
Have you ever had a stinger or burner or pinched nerve in the neck?	_____	_____
8. Have you ever had heat cramps or muscle cramps?	_____	_____
Have you ever been dizzy or passed out in the heat?	_____	_____
9. Have you had any problems with eyes or vision?	_____	_____
Do you wear glasses or contacts or protective eyewear?	_____	_____
10. Do you wear any dental appliances (braces, false teeth)?	_____	_____
11. Do you have any ear drum tubes or a perforated eardrum?	_____	_____
12. Have you had any medical problems (i.e. infectious mononucleosis, diabetes, etc.)?	_____	_____
13. Have you had any medical problems or injury since your last physical evaluation?	_____	_____
14. Have you ever been told not to participate in physical activity?	_____	_____
15. When was your last tetanus (Td) shot?	_____ (month)	_____ (year)
16. When was your last measles (MMR) immunization?	_____ (month)	_____ (year)

Approval to Participate Statement

I have on this date I examined this student and that on the basis of this examination and the person’s medical history as furnished to me, this individual may or may not participate in the I Can Do It, You Can Do It program with the types of physical activities described on page one, or may participate with the limitations noted as indicated below.

_____ Cleared; no limitations

_____ Cleared with the following limitations:

_____ Not cleared

Licensed Health Care Provider Signature

Date of Examination

Printed Name

Circle Degree: MD/DO/PA/CNP/FNP/CNM/DC

Address

Phone

Participant or Parent/Guardian sign here:

Participant (Or Parent/Guardian if under 18) Signature

Date

Please return the completed form to your Agency Coordinator.