The Gym Park Corp.
81 Oak Street Greenpoint, N.Y. 11222
(718) 349-6627
Info@TheGymPark.com

# MEDICAL CLEARANCE FORM

Print Athlete's name: _____ Date Of Birth : ___/____/____

## PHYSICIAN'S STATEMENT

I have examined _____, and found him/her to be able to participate in a program of Rigorous Physical exercise including competitive artistic gymnastics.

Known Allergies, Physical Limitations, and/or Doctor's Comments:_____

_____

_____

_____

_____DATE: ____/____/____
PHYSICIAN'S SIGNATURE

## PHYSICIAN'S INFORMATION

PHYSICIAN'S Name:_____
(Print)
Address: _____

_____

Telephone number:_____

License Number: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

# MEDICAL HISTORY

**YES NO** **IMMUNIZATIONS**

___ ____ Tetanus: Date of last booster _____/_____/_____

**GENERAL**

____ ____ Are you currently taking any medications? If so list them here:
_____

____ ____ Do you have Any allergies? If so list them here:
_____

____ ____ Have you had any major illnesses in the last two years? If so list them here:
_____

____ ____ Have you ever had surgeries?. If so list them here:
_____

____ ____ Do you have hemophilia or a bleeding disorder?
____ ____ Do you have diabetes*?*
____ ____ Do you have anemia?
____ ____ Have you ever been advised by a medical doctor not to participate in any athletic activities
____ ____ Do you have any missing body parts (eye, kidney, etc.)?
____ ____ Have you ever had an eating disorder?

**EYES**

____ ____ Do you have poor vision in either eye?
____ ____ Do you wear glasses or contact lenses?
____ ____ Do you have blurred vision?
Do you have double vision?

**EAR, NOSE AND THROAT**

____ ____ Do you have frequent nose bleeds?
____ ____ Do you have frequent sore throats?
____ ____ Do you have frequent ear infections?
____ ____ Have you noticed decreased hearing in either ear?

**CARDIOVASCULAR**

____ ____ Have you ever had rheumatic fever or scarlet fever?
____ ____ Do you have a heart murmur?
____ ____ Do you have high blood pressure?
____ ____ Do you ever get any chest pain?
____ ____ Do you ever get palpitations (extra strong or irregular heart beats)?

**CHEST/PULMONARY**

____ ____ Have you ever had pneumonia?
____ ____ Do you have asthma?
____ ____ Are you frequent short of breath?
____ ____ Do you ever wheeze?

**ABDOMINAL**

____ ____ Do you have frequent abdominal pain?
____ ____ Do you have or have ever had an ulcer?
____ ____ Have you ever had hepatitis? Have you ever had a hernia?

**NEUROLOGIC**

____ ____ Do you have occasional dizziness?
____ ____ Do you ever faint?
____ ____ Do you ever have frequent and severe headaches?
____ ____ Have you ever had a neck injury?
____ ____ Have you ever had seizures or epilepsy. If yes give most recent date _____/_____/____