

Department of Athletics

Interim Assessment

Name: _____ Sport: _____

Grade: _____ Today's Date: _____

Please circle

- | | | |
|--|-----|----|
| 1. Have you been previously examined within the past 365 days? | Yes | No |
| 2. Which sport? _____ | | |
| 3. Were you examined by your own physician? | Yes | No |
| 4. Were you examined by the school physician? | Yes | No |

Since your *last* physical examination:

- | | | |
|--|-----|----|
| 1. Have you been hospitalized or had any operations? | Yes | No |
| 2. Are you taking any medications? | Yes | No |
| 3. Have you been under a doctor's care? | Yes | No |
| 4. Have you sustained any injuries or illness? | Yes | No |
| 5. Were you cleared for sports participation by the physician? | Yes | No |

If you answered **yes** to any of the above, explain below:

Physician Name: _____

Address: _____

Parent/ Guardian Signature

Note: This form is to be used only if the athlete's physical examination took place more than 60 days prior to the first practice session