

SEADO Enterprises
 “A Sports and Information Referral Service”

**“The McNabb Challenge”
 Medical Screening Form**

The requirement for attending the pro clinic and or combine is to complete all forms and return all forms by fax or US mail to SEADO Enterprises prior to clinic or combine.

Please print or type all information.

First Name: _____ MI: _____ Last Name: _____

Current High School: _____ Graduation Year (yyyy): _____

Student Medical History:

Check Off Appropriate Box

Do you now have or ever had the following:

- | | | |
|--|------------------------------|-----------------------------|
| Irregular Heart Beat | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any one in immediate family had heart problems before age 50 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulty breathing after exercising | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High Blood Pressure (Hypertension) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Blood Clots | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Present Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Have you ever:

- | | | |
|--|------------------------------|-----------------------------|
| Had an operation or surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Been restricted from playing athletics | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Been knocked Out or unconscious | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainted after during or after exercising | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Suffered a concussion | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stayed overnight at the hospital | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Had heat exhaustion or heat stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Broken any bones or limbs (fingers, legs, arms etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Been placed on medication by a doctor | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Do you presently:

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| Wear glasses | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hearing aid or wear dental appliances | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

This form must be completed and signed by both the student and parent/guardian before our physical examination can be administered. Your signatures confirm that you have read and understand all information listed above and you give your permission and consent to emergency and or medical treatment.

Parent/Guardian Signature: _____ Date: _____

Athlete/Participant Signature: _____ Date: _____