Sports Participation Health Record

This Evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. *THIS SIDE MUST BE COMPLETED BY PARENT & STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.*

NAME _____ AGE ____ SEX ____ SCHOOL _____

ADDRESS _____ PHONE _____ ENTERING GRADE: _____

SPORTS BEING PLAYED (1) _____ (2) _____ (3) _____

MEDICAL HISTORY

(To be completed by student and parent or guardian)

1. Do you have any allergies? ((Drugs, Food, Insect Stings, etc.)
   _____YES; list: _____ _____ NO
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or Occasionally)
   _____YES; list: _____ _____ NO
3. Are you presently being treated for any condition, by a physician or other health-care professional?
   _____YES; explain: _____ _____ NO
4. Have you ever been advised by a doctor, not to participate in any sport?
   _____YES; explain: _____ _____ NO
5. Do you have any chronic conditions, disorders or diseases? Check those that apply, or → → → → _____ NO

   ____ Asthma ____Bleeding Disorders ____Diabetes _____Epilepsy (Seizures)
   ____ Hepatitis (liver disease) ____Hypertension (High Blood Pressure) ____Sickle Cell Anemia _____Other ? _____
   ____ Mononucleosis (Year) ____ ____Kawasaki's Disease ____Handicap (describe) _____

Please check where applicable if you now have or have had any of the following:

	YES	NO		YES	NO
Head injury, concussion or been unconscious If yes, how many times?			Eye injury or retinal detachment		
Headaches more than once a week			Blurred vision or vision in one eye only		
Lack of feeling or numbness in any part of the body			Wear glasses or contact lenses		
Heat exhaustion or heat stroke			Hearing loss or impairment in one or both ears		
Difficulty running ½ mile without stopping			Tubes in ear(s) or a perforated eardrum		
Chest pain, dizziness or passing out during exercise			False teeth, caps or braces		
Coughing, wheezing or gasping for breath With exercise or cold weather			Nose bleeds for no reason		
Smoke cigarettes or chew tobacco			Bruising easily or taking a long time to stop bleeding when cut		
Heart problem, murmur or arrhythmia			Diarrhea more frequent than once a week		
Family member with a heart attack before age 50			Black or bloody bowel movements (stools)		
Loss or gain of more than 10 lbs in the last year			Kidney disease or dark, brown or bloody urine		
Special diet for medical reasons			Less than two kidneys *or in males*, two testicles		
For Female Participants only:			Lump(s) in arm pit or groin		
Absent or irregular monthly periods			Rash or skin problem		
Disabling cramps with your menstrual periods			Neck, spine or low-back injury or pain		
Have you *ever been hospitalized* for medical or surgical reasons ? → → → → →					

If yes, provide the following: REASON	YEAR	HOSPITAL

Please carefully list below any injury (nerve, muscle, bone or joint) you have suffered which prevented your participation in regular activity for one week or more

INJURED AREA (Knee, Hamstring, Neck, Shin, etc.)	YEAR	SIDE (R,L)	TYPE (Fracture, Sprain, Swelling, Pinched Nerve, etc.)	RESOLVED ?? YES	NO

STUDENT AND PARENT OR GUARDIAN:

We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

_____ _____

Student Athlete Parent / Guardian

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
PHYSICAL MATURITY (TANNER STAGE) 1 2 3 4 5		

HEIGHT _____ WEIGHT _____

BLOOD PRESSURE _____ PULSE _____

HCT / HGB _____

URINALYSIS: _____Protein _____Blood _____Glucose

VISUAL ACUITY: _____RIGHT _____ LEFT

CORRECTED TO: _____RIGHT _____ LEFT

HEARING: _____

BODY FAT (Optional) - _____ %

CHOLESTEROL (Optional) - _____

LAST TETANUS BOOSTER Date: _____

LAST MEASLES (MMR) BOOSTER Date: _____

OTHER IMMUNIZATIONS Date: _____

SUMMARY: _____

ORTHOPEDIC EXAM

MUSCULOSKETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH AND FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS / HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

RECOMMENDATIONS

WEIGHT LOSS / GAIN _____

STRENGTHENING _____

STRETCHING _____

CONDITIONING (Endurance) _____

MEDICATION(S) _____

SPECIAL EQUIPMENT _____

BRACING / TAPING _____

I certify that on this date I have examined this student and that on the basis of the examination requested by school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:

_____

_____

_____ M.D. _____ _____

SIGNATURE OF MEDICAL DOCTOR DATE OF EXAM ** MEDICAL DOCTOR / PRINT OR STAMP NAME & ADDRESS

** Note

If this physical expires mid-season, it is the parent's and student's responsibility to obtain a current Sports Physical and provide it to the Health Office. Your physical is ***valid for One Year. Only students with a current Sports Physical may participate in athletics.***