

# 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 \_\_\_\_\_ 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 medication 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 applicable or → → → → → → → → → → → → \_\_\_\_\_ NO  
 \_\_\_\_\_ Asthma                      \_\_\_\_\_ Bleeding Disorders                      \_\_\_\_\_ Diabetes                      \_\_\_\_\_ Epilepsy (Seizures)  
 \_\_\_\_\_ Hepatitis                      \_\_\_\_\_ Hypertension (High Blood Pressure)                      \_\_\_\_\_ Sickle Cell Anemia                      \_\_\_\_\_ (Other) \_\_\_\_\_  
 \_\_\_\_\_ Mononucleosis-Yr \_\_\_\_\_ \_\_\_\_\_ Kawasaki's Disease                      \_\_\_\_\_ Handicap (Describe) \_\_\_\_\_

Please check where applicable if you 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 ears 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 than once a week	_____	_____
Family member with a heart attack under age 50	_____	_____	Black or bloody bowel movements (stools)	_____	_____
Loss or gain of more than 10 lbs. in last year	_____	_____	Kidney disease or dark, brown or bloody urine	_____	_____
Special diet for medical reasons	_____	_____	Less than two kidneys or, in males, two testicles	_____	_____
<i>For female participants:</i>			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? → → → → → → → → → → → → → → → → → YES NO

If yes, provide the following information:

<u>REASON</u>	<u>YEAR</u>	<u>HOSPITAL</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more?

<u>INJURED AREA</u> (Knee, Hamstring, Neck, Shin, etc.)	<u>YEAR</u>	<u>SIDE</u> (R, L)	<u>TYPE</u> (Fracture, Sprain, Swelling, Pinched Nerve, etc.)	<u>RESOLVED</u> 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 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL EXAMINATION -- To Be Completed By Medical Doctor or his designee**

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) <b>1 2 3 4 5</b>		

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**

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

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

**RECOMMENDATIONS**

WEIGHT LOSS/GAIN \_\_\_\_\_ MEDICATIONS \_\_\_\_\_  
 STRENGTHENING \_\_\_\_\_ SPECIAL EQUIPMENT \_\_\_\_\_  
 STRETCHING \_\_\_\_\_ BRACING/TAPING \_\_\_\_\_  
 CONDITIONING (Endurance) \_\_\_\_\_

I certify that on this date I have examined this student and that, on the basis of the examination requested by the 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 complete in supervised athletic activities except those listed below:

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE OF MEDICAL DOCTOR M.D. \_\_\_\_\_ DATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_ MEDICAL DOCTOR PRINT OR STAMP \_\_\_\_\_