

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

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>	<u>YEAR</u>	<u>SIDE</u>	<u>TYPE</u>	<u>RESOLVED</u>	
(Knee, Hamstring, Neck, Shin, etc.)		(R, L)	(Fracture, Sprain, Swelling, Pinched Nerve, etc.)	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) 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

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 _____