

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 the student and parent or guardian)

1. Do you have any allergies? (Drugs, Food, Insect Stings, etc)
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally)
3. Are you presently being treated for any conditions by a physician or other health care professional?
4. Have you ever been advised by a doctor not to participate in any sport?
5. Do you have any chronic conditions, disorders or diseases? Check those applicable.
 _____ No _____ Hepatitis (Liver disease) _____ Bleeding Disorders _____ Epilepsy (Seizures)
 _____ Asthma _____ Hypertension (High Blood Pressure) _____ Sickle Cell Anemia _____ Diabetes
 _____ Mononucleosis – Yr. _____ Handicap (Describe) _____
 _____ Other _____

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 lens	_____	_____
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 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 grasping for breath	_____	_____	Bruising easily or taking a long time to stop	_____	_____
With exercise of 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 or 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	_____	_____
Rash or skin problems	_____	_____	Neck, spine or low back injury or pain	_____	_____
For female participants:					
Absent or irregular monthly periods	_____	_____	Disabling cramps with your menstrual periods	_____	_____

Have you ever been hospitalized for medical or surgical reason? Yes _____ No _____

If yes, provide the following information:

REASON	YEAR	HOSPITAL
_____	_____	_____
_____	_____	_____

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.

INJURED AREA	YEAR	SIDE	TYPE	RESOLVED
(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 _____

NAME _____ DATE OF EXAM _____

DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
- Arrhythmia		
- Murmur		
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
PHYSICAL MATURITY		
- (TANNER STAGE) 12345		

HEIGHT _____ WEIGHT _____
BLOOD PRESSURE _____
PULSE _____

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 _____
 CONDITIONG (Endurance) _____

I verify 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 compete in supervised athletic activities except those listed below:

Signature Medical Doctor (M. D.) _____ Date _____ Telephone _____ Medical Doctor (Print or Stamp) _____