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 (Knee, Hamstring, Neck, Shin, etc)	YEAR	SIDE (R, L)	TYPE (Fracture, Sprain, Swelling, Pinched Nerve, etc)	RESOLVED Yes	RESOLVED 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)