

SPORTS PARTICIPATION MEDICAL EXAMINATION

To be completed by the Physician, RN, APRN, or PA. This medical examination is valid for one calendar year.

Name: _____ Date of Birth: _____ **Date of Exam** _____

General Exam

	Normal	Abnormal Findings
Appearance		
Skin		
Heart		
Respiratory		
Cardiovascular		
		Arrhythmia
		Murmur
Abdomen		
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: _____
 HBV 1 _____ 2 _____ 3 _____
 Varicella Disease Date _____ OR
 Varicella Immunization 1 _____ 2 _____
 Other Immunizations _____

Chronic Disease Assessment

___ Asthma: ___ mild ___ moderate ___ severe
 ___ exercise induced ___ unclassified
 ___ Diabetes ___ Type I ___ Type II
 ___ Anaphylactic Reaction: ___ food ___ insect ___ latex
 ___ Seizure Disorder
 ___ Other: Please specify _____

Orthopedic Exam

Musculoskeletal Evaluation to include range of motion, strength, flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Postural		Min. ___ Slight ___ Mod. ___ Marked ___
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 compete in supervised athletic activities except those listed below:

 Signature of Physician, RN, APRN,PA

 Telephone

 Provider Print or Stamp

Sports Participation Health Record

This evaluation is to determine readiness for sports participation. This must be completed by a parent and 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/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 applicable or ... _____ No

_____ Asthma	_____ Bleeding Disorders	_____ Diabetes	_____ Epilepsy(Seizures)
_____ Hepatitis(liver disease)	_____ Hypertension(High Blood Pressure)	_____ Sickle Cell Anemia	_____ Other _____
_____ Mononucleosis-Yr _____	_____ Kawasaki Disease	_____ Disability (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 1/2 mile without stopping	___	___	Tubes in ears or perforated ear drum	___ ___
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	___ ___
For female participants			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 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.

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/Guardian Signature	Date
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