

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME		FIRST NAME		GRADE
BIRTHDATE	FALL SPORT	SPRING SPORT	STUDENT ID NUMBER	

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

	Yes	No	Has this student had:		Yes	No	Has this student had:
1.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent illness?	16.	<input type="checkbox"/>	<input type="checkbox"/>	Injuries requiring medical care or treatment?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Illness lasting over 1 week?	17.	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back pain or injury?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations or Surgeries?	18.	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain or injury?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, psychiatric, or neurologic condition?	19.	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder or elbow pain or injury?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	20.	<input type="checkbox"/>	<input type="checkbox"/>	Ankle pain or injury? Other joint pain or injury?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (medicines, insect bites, food)?	21.	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones (fractures)?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?	22.	<input type="checkbox"/>	<input type="checkbox"/>	Yes No Does this student presently:
8.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or significant or severe shortness of breath during or after exercise?	23.	<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses or contact lenses?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with exercise?	24.	<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces or plates?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, bad headaches or convulsions?	25.	<input type="checkbox"/>	<input type="checkbox"/>	Take any medications? (List below):
11.	<input type="checkbox"/>	<input type="checkbox"/>	Potential concussion or loss of consciousness?	26.	<input type="checkbox"/>	<input type="checkbox"/>	Yes No Further history:
12.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion, heatstroke, or other problems managing or responding to heat?	27.	<input type="checkbox"/>	<input type="checkbox"/>	Birth defects (corrected or not)?
13.	<input type="checkbox"/>	<input type="checkbox"/>	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?	28.	<input type="checkbox"/>	<input type="checkbox"/>	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
14.	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or seizure disorders?	29.	<input type="checkbox"/>	<input type="checkbox"/>	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
15.	<input type="checkbox"/>	<input type="checkbox"/>	Severe or repeated instances of muscle cramps?				Been seen by a physician on an emergency or urgent basis in the last 12-months?

Date of last known tetanus (lockjaw) shot: _____

Date of last complete physical examination: _____

Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS		WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME		OFFICE PHONE		

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

NORMAL ABNORMAL (Describe) (May be contained on Provider's Form)

Eyes/Ears/Nose/Throat

Height: Weight:

Heart, lungs, pulmonary function

Pulse: After Ex:

Abdomen, genital/hernia (males)

BP:

Skin and Musculoskeletal:

Recommendation, please circle one:

- a. Neck/Spine/Shoulders/Back
- b. Arms/Hands/Fingers
- c. Hips/Thighs/Knees/Legs
- d. Feet/Ankles

Neurologic Screening Exam (NSE)/

Concussion Screening Evaluation
(only if needed based on above info.)

Comments:

1. Unlimited participation
2. Limited participation/specific sports, events or activities
3. Clearance withheld pending further testing/evaluation
4. No athletic participation

PHYSICIAN'S STAMP

PHYSICIAN'S SIGNATURE

DATE