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 with exercise or cold weather	☐	☐	Bruising easily or taking a long time to stop 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	☐	☐
For female participants:			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:

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**

MEDICAL EXAMINATION -- To Be Completed By Medical Doctor or his designee

NAME_____ DATE OF BIRTH_____

GENERAL EXAM

	Normal	Abnormal Findings
APPERANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
PHYSICAL MATUTURITY (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:

_____

_____

_____ M.D. _____ _____ _____

SIGNATURE OF MEDICAL DOCTOR DATE TELEPHONE MEDICAL DOCTOR PRINT OR STAMP

This form was approved and developed by: Connecticut Chapter, Committee on Sports Medicine – American Academy of Pediatrics
Connecticut Chapter, Committee on School Health – American Academy of Pediatrics
The Connecticut State Medical Society Committee on the Medical Aspects of Sports