

SPORTS PARTICIPATION MEDICAL EXAMINATION

To the Health Care Provider – Please complete and sign

*Mandated Screening/Test under CT State Law

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:* _____
 Gross Dental:* _____

Body Fat _____ % Cholesterol _____ %

Last Tetanus Booster _____ Date: _____ Last Measles(MMR) Booster _____ Date: _____ HBV 1 _____ 2 _____ 3 _____ Varicella Disease Date _____ OR Varicella Immunization 1 _____ 2 _____

Chronic Disease Assessment*

Yes No
 ___ ___ Asthma: ___ mild ___ moderate ___ severe
 ___ exercise induced ___ unclassified
 ___ ___ Diabetes ___ Type I ___ Type II

TB: IN HIGH RISK GROUP ___ YES ___ NO
TB TEST DATE RESULTS

___ ___ Seizure Disorder _____
 ___ ___ Anaphylactic Reaction: ___ food ___ insect ___ latex
 ___ ___ Other: Please specify _____

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		

Comments and Recommendations

Weight loss/gain _____ Medications _____
 Strengthening _____ Special Equipment _____
 Stretching _____ Bracing/Taping _____
 Conditioning (endurance) _____ Comments _____

•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:

 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	_____	_____	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 perforated ear drum _____	_____	_____
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?

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.

_____	Date	_____	Date
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