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: Bobby Baseball Age: 15 Sex: M School FLHS
Address: 1 Main St. Phone: 203-255-0000 Grade: 10
Sports being played (1) Baseball (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
Head injury, concussion, or been unconscious		
If yes, how many times_____		
Headaches more than once a week		
Lack of feeling or numbness in any part of the body		
Heat exhaustion or heat stroke		
Difficulty running ½ mile without stopping		
Chest pain, dizziness or passing out during exercise		
Coughing, wheezing or gasping for breath with exercise or cold weather		
Smoke cigarettes or chew tobacco		
Heart problem, murmur or arrhythmia		
Family member with a heart attack under age 50		
Loss or gain of more than 10 lbs. in last year		
Special diet for medical reasons		
For female participants		
Absent or irregular monthly periods		
Disabling cramps with your menstrual periods		

	Yes	No
Eye injury or retinal detachment		
Blurred vision or vision in one eye only		
Wear glasses or contact lenses		
Hearing loss or impairment in one or both ears		
Tubes in ears or perforated ear drum		
False teeth, caps or braces		
Nose bleeds for no reason		
Bruising easily or taking a long time to stop bleeding when cut		
Diarrhea more than once a week		
Black or bloody bowel movements (stools)		
Kidney disease or dark, brown or bloody urine		
Less than two kidneys or in males, two testicles		
Lump(s) in arm pit or groin		
Rash or skin problem		
Neck, spine or low back injury or pain		

Have you ever been hospitalized for medical or surgical reasons?
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 hearby 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 _____

SPORTS PARTICIPATION MEDICAL EXAMINATION

To the Health Care Provider – Please complete and sign *Mandated Screening/Test under CT State Law

Name: Bobby Baseball Date of Birth: 6.11.2005 **Date of Exam:** 8.30.2020

General Exam	Normal	Abnormal Findings
Appearance		
Skin		
Heent		
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 %

Chronic Disease Assessment*

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

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

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