ENGLEWOOD HIGH SCHOOL -- ATHLETIC HEALTH HISTORY

Student or Parent: Please complete this side of the form Date of Birth_____
PRIOR to student's physical exam

Name_____ Age_____ Grade_____ Female___ Male___

List the sports that you will be participating in:

Fall_____ Winter_____ Spring_____

	Yes	No
1. Have you ever been hospitalized (overnight)?		
2. Have you ever had surgery? If yes, list below.		
3. Do you have any allergies (e.g., medication, bee stings)? If yes, list below.		
4. Have you ever passed out during exercise (not from heat)?		
Have you ever been dizzy during exercise (not from heat)?		
Do you cough, wheeze, or have a shortness or breath during exercise?		
5. Have you ever had high blood pressure?		
Have you ever been told you had a heart murmur		
Has your heart ever raced or skipped beats?		
Has anybody in your family died suddenly or of heart problems before 40?		
Does anyone in your family have Marfan's syndrome?		
6. Have you ever had a concussion or other head injury? If yes, list below.		
7. Have you ever had a seizure?		
Have you ever had a burner/stinger (pain from the neck to arm)?		
8. Have you ever had heat cramps?		
Have you ever been dizzy or passed out in the heat?		
9. Do you wear special pads or braces when you exercise?		
10. Do you drink milk products or eat dairy foods?		
Do you consume more than 12 ounces of soda per day?		
11. Have you had a tetanus shot (or booster) within the last 5 years?		

12. Have you ever injured (broken/ fractured, sprained, dislocated) any of the following areas? Check all that apply:

____Ankle ____Back ____Elbow ____Foot/toes ____Forearm ____Wrist/hand/finger

____Hip ____Knee ____Lower Leg ____Shoulder ____Thigh ____Upper arm

13. Have you ever had or do you currently have any of the following medical problems? Check all that apply:

____Asthma ____Diabetes ____Hepatitis ____Hernia(s) ____Measles

____Mononucleosis ____Tuberculosis ____Stress fractures ____Ulcers ____Sickle cell trait/disease

The above information is current and correct to the best of my knowledge.

_____ _____

Parent/Guardian signature Date

PHYSICAL EXAMINATION

Name: _____ BP_____ Vision: Left eye_____

Weight: _____ Pulse_____ Right eye_____

Height: _____ % Body Fat: _____ Both eyes_____

Corrected/Uncorrected_____

✓ = within normal limits x = see comments ND = not done/omitted

Skin		Genitals (optional)	
Head		Extremities	
Eyes		Neurological	
		Reflexes	
Ears, Nose, Throat			
		Orthopedic	
Neck		Cervical spine/back	
		Arms/elbows/wrists/hands	
Lymphatics		Hips	
		Knees	
Respiratory		Ankles/feet	
Cardiovascular		Developmental	
Heart (murmurs?)		Tanner staging: 1-5 (optional)	
Pulses			
Abdomen			

Comments/Recommendations:

Medical Clearance (as appropriate for age and development)

_____Full contact/collision level

_____Limited contact/impact

_____Non-contact: strenuous

_____Non-contact: non-strenuous

_____ Clearance deferred or no participation at this time.

_____

_____

_____

_____MD/DO/FN/PA _____ _____

Provider signature Date of Exam Phone #