(Revised & Approved on 6/2/2008 by Student Health Services and Medical Advisory Committee)

Student Name_____ DOB_____ School _____

Sport(s) _____ Student ID# _____

An athletic screening arranged by the school district is not a complete physical examination. It is a screening to detect obvious impairments that might affect the student's safety in sports participation. This screening should not be used as a substitute for regular health maintenance examinations with your personal physician.

Printed Name of Parent/Guardian_____ Signature _____

Phone number _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN: PLEASE CHECK YES OR NO FOR THE FOLLOWING QUESTIONS

		Yes	No
1.	Chronic or recurrent illness? (asthma, diabetes, hepatitis, kidney disease, rheumatic fever)	____	____
2.	Hospitalizations?	____	____
3.	Any surgeries?	____	____
4.	Missing organs (eye, kidney, testicle)?	____	____
5.	Allergies – pollen/bees/food/medicines?	____	____
6.	Problems with heart, heart murmur, or blood pressure?	____	____
7.	Chest pain with exercise?	____	____
8.	Dizziness, fainting, frequent headaches?	____	____
9.	Convulsions/seizures?	____	____
10.	Any concussions/unconscious?	____	____
11.	Any heat exhaustion/heatstroke?	____	____
12.	Skin problems? Ringworm?	____	____
13.	Does this student wear eyeglasses/contacts?	____	____
14.	Taking steroids now or in past?	____	____
15.	Mononucleosis within last year?	____	____
16.	Does this student take medication on a routine or daily basis? Use inhaler?	____	____
17.	Under care of doctor?	____	____
	IS THERE ANY HISTORY OF:		
18.	Injuries requiring doctor treatment?	____	____
19.	Neck/back/spine injury or pain?	____	____
20.	Knee/hip injury or pain?	____	____
21.	Hand/wrist/arm injury or pain?	____	____
22.	Is there any reason why this student should not participate in sports?	____	____
23.	Has any family member died suddenly at less than 40 years of age?	____	____
24.	Has any family member had a heart attack at less than 55 years of age?	____	____

Date of last tetanus_____

FEMALES: Age of onset of periods _____
Are your periods regular or irregular (circle one)
Date of last period_____

HT_____ WT_____ BMI_____ BP_____/_____ HGB_____(as necessary)

Vision Right_____ /_____ Left_____/_____with/without corrective lenses (circle one)

Pulse rate resting _____ After exercise_____ Recovery rate satisfactory? Yes or No

PHYSICAL SCREENING

GENERAL_____ HEENT_____ LUNGS_____

HEART_____ GI/ABDOMEN_____ GU/HERNIA_____

NECK/BACK_____ EXTREMITIES_____

Comments_____

☐ **DENIED** This student has health problems that prohibit him/her from participating in competitive sports:

_____

☐ **FOLLOW-UP** This student needs to have the following health problems evaluated or treated before participation can be recommended:_____

☐ **RECOMMEND** To the best of my knowledge, the above named student is physically able to participate in interscholastic athletics.

_____ _____ _____
Physician's Name (please print) Physician's Signature Date

Physician's License Number_____ Physician's Phone_____

*A Medical Doctor/Nurse Practitioner/Physician's Assistant, must sign this form