

# 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	_____	_____	Bruising easily or taking a long time to stop	_____	_____
with exercise or cold weather	_____	_____	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	_____	_____
<i>For female participants:</i>			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:

<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?

<u>INJURED AREA</u>	<u>YEAR</u>	<u>SIDE</u>	<u>TYPE</u>	<u>RESOLVED</u>
(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.

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
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
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: \_\_\_\_\_

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