SPORTS PARTICIPATION HEALTH RECORD

THIS EVALUATION IS ONLY TO DETERMINE READINESS FOR SPORTS PARTICIPATION. IT SHOULD NOT BEE USED AS A SUBSTITUTE FOR MAINTENANCE EXAMINATION.

NAME_________________________________ AGE _______ GRADE _______ DATE ___________

ADDRESS____

HOME PHONE _________________ CELL PHONE _________________ OTHER __________________

TO BE COMPLETED BY THE ATHLETE OR PARENT.

PART A-HEALTH HISTORY

1. Have you ever had an illness that:
   a. required you to stay in the hospital?
      YES _____ NO______
   b. lasted longer than a week?
      YES _____ NO _____
   c. caused you to miss 3 days of practice or competition? YES _____ NO _____
   d. is related to allergies? YES _____ NO _____
   e. required an operation? YES _____ NO _____
   f. is chronic? YES_____ NO _____
2. Have you ever had an injury that:
   a. required you to go to an emergency room or see a doctor? YES _____ NO _____
   b. required you to sty in the hospital?
      YES _____ NO _____
   c. required an X-ray? YES _____ NO _____
   d. caused you to miss 3 days of practice or a competition? YES _____ NO _____
   e. required an operation ? YES _____ NO _____
3. Do you take any medicine or pills?
   YES _____ NO _____
4. Have any members of your family under age 50 had a heart attack, heart problem, or died unexpectedly?
   YES _____ NO _____
5. Have you ever?
   a. been dizzy or passed out during or after exercise?
   YES _____ NO ______
6. Are you unable to run ½ mile (two times around track) without stopping? YES _____ NO _____
7. Do you?
   a. wear glasses or contacts? YES _____ NO _____
8. Have you ever had a heart murmur?
   YES _____ NO _____
9. High blood pressure or heart abnormality?
   YES _____ NO _____
10. Are you missing a kidney?
   YES _____ NO _____
11. When was your last tetanus booster? _________

PART B-INTERIM HEALTH HISTORY

1. Over the next 12 months I wish to participate in the following sports: (please list)
   ____
   ____
   ____
2. Have you missed more than 3 consecutive days of? participation in usual activities because of an injury this past year? YES _____ NO _____
   If yes, please indicate:
   a. site of injury__________________________
   b. type of injury _________________________
3. Have you missed more than 5 consecutive days of participation in usual activities because of an illness, or Have you had a medical illness diagnosed that has not been resolved in the past year? YES _____ NO _____
   Type of illness________________________________
4. Have you had a seizure, concussion or been unconscious for any reason in the past year YES _____ NO _____
5. Have you had surgery or been hospitalized in the past year?
   YES _____ NO _____
   a. Reason for hospitalization________________________
   b Type of surgery ________________________________
6. List all medications you are presently taking and what
   a. ____
   b. ____
   c. ____
7. Are you worried about any problem or condition at this time?
   YES _____ NO _____
   If yes, please explain: _____________________________
   ____

EXPLAIN ANY "YES" ANSWERS___________

____

____

____

I HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, THE ANSWERS TO THE ABOVE ARE TRUE AND CORRECT.

___________________________   ___________________________

Physical Examination Record

Name ______________________ **Date** __________ **Age** ________

Height __________ **Weight** __________ **B/P** __________ **Pulse** ________

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Eye			
2. Ears, Nose, Throat			
3. Mouth and Teeth			
4. Neck			
5. Cardio Vascular			
6. Chest and Lungs			
7. Abdomen			
8. Skin			
9. Genitalia-Hernia (Male)			
10. Musculoskeletal: ROM, Strength			
a. Neck			
b. Spine			
c. Shoulders			
d. Arms/ Hands			
e. Hips			
f. Thighs			
g. Knees			
h. Ankles			
i. Feet			
11. Neuromuscular			
12. Physical Maturity- Tanner Stage			

Comments Regarding Abnormal Findings: ______________________

____

Participation Recommendations:

1. No participation in: ______________________

2. Limited participation in: ______________________

3. Requires: ______________________

4. Full participation in: ______________________

Health Provider Signature ______________ **Date** __________

Health Provider Name ______________ **License No.** __________