

SPORTS PARTICIPATION MEDICAL EXAMINATION

To the Health Care Provider – Please complete and sign ***Mandated Screening/Test CT State Law and Fairfield Regulations for Sports Exam**

Name: _____ Date of Birth: _____ Date of Exam: _____

General Exam	Normal	Abnormal Findings
Appearance		
Skin		
Heart		
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

* **TB: IN HIGH RISK GROUP** ___ YES ___ NO

___ Seizure Disorder

___ Anaphylactic Reaction: ___ food ___ insect ___ latex

___ Other: Please specify _____

Last Tetanus Booster Date: _____

Last Measles(MMR) Booster Date: _____

HBV 1 _____ 2 _____ 3 _____

Varicella Disease Date _____ OR

Varicella Immunization 1 _____ 2 _____

TB TEST

DATE

RESULTS

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

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: _____ Age: _____ Sex: _____ School _____
 Address: _____ Phone: _____ Grade: _____
 Sports being played (1) _____ (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		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 perforated ear drum	___	___
Difficulty running 1/2 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 with exercise or cold weather _____			Bruising easily or taking a long time to stop 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	___	___
For female participants			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?

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.

Injured Area	Year	Side	Type	Resolved	
(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/Guardian Signature _____ Date _____