SPORTS PARTICIPATION MEDICAL EXAMINATION

To the Health Care Provider – Please complete and sign ***Mandated Screening/Test under CT State Law**

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

General Exam	Normal	Abnormal Findings
Appearance		
Skin		
Heent		
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 _____%

Last Tetanus Booster Date:_____
Last Measles(MMR) Booster Date:_____
HBV 1_____2_____3_____
Varicella Disease Date_____OR
Varicella Immunization 1_____2_____

Chronic Disease Assessment*
Yes No
__ __ Asthma:__mild__moderate__severe
__exercise induced__unclassified
__ __ Diabetes__Type I__Type II

* **TB: IN HIGH RISK GROUP** ___YES ___ NO
TB TEST DATE RESULTS
_____

__ __ Seizure Disorder
__ __ Anaphylactic Reaction:__ food __ insect __ latex
__ __ Other: Please specify_____

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 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 bleeding		
with exercise or cold weather	___	___	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:

Reason	**Year**	**Hospital**
_____	_____	_____
_____	_____	_____

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 (knee, Hamstring, Neck, Shin, etc.)	Year	Side (R/L)	Type (Fracture, Sprain, Swelling, Pinched Nerve, etc.	Resolved Yes	Resolved No
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____

Student and Parent or Guardian:

We hearby 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

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