PART III – STUDENT'S MEDICAL HISTORY

(To be completed by parent or guardian prior to examination)

Name _____ Birthdate _____/_____/_____ Grade _____ Age _____

Has the student ever had:

Yes No 1. Chronic or recurrent illness? (Diabetes, Asthma, Seizures, etc.,)
Yes No 2. Any hospitalizations?
Yes No 3. Any surgery (except tonsils)?
Yes No 4. Any injuries that prohibited your participation in sports?
Yes No 5. Dizziness or frequent headaches?
Yes No 6. Knee, ankle or neck injuries?
Yes No 7. Broken bone or dislocation?
Yes No 8. Heat exhaustion/sun stroke?
Yes No 9. Fainting or passing out?
Yes No 10. Have any allergies?
Yes No 11. Concussion? If Yes _____ Date(s)

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS.

Yes No 12. Have any problems with heart/blood pressure?
Yes No 13. Has anyone in your family ever fainted during exercise?
Yes No 14. Take any medicine? List _____
Yes No 15. Wear glasses ___, contact lenses___, dental appliances___?
Yes No 16. Have any organs missing (eye, kidney, testicle, etc.)?
Yes No 17. Has it been longer than 10 years since your last tetanus shot?
Yes No 18. Have you ever been told not to participate in any sport?
Yes No 19. Do you know of any reason this student should not participate in sports?
Yes No 20. Have a sudden death history in your family?
Yes No 21. Have a family history of heart attack before age 50?
Yes No 22. Develop coughing, wheezing, or unusual shortness of breath when you exercise?
Yes No 23. (Females Only) Do you have any problems with your menstrual periods.

I also give my consent for the physician in attendance and the appropriate medical staff to give treatment at any athletic event for any injury.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____/_____/_____

PART IV – VITAL SIGNS

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Visual acuity: Uncorrected _____/_____; Corrected _____/_____; Pupils equal diameter: Y N

PART V – SCREENING PHYSICAL EXAM

This exam is not meant to replace a full physical examination done by your private physician.

Mouth:			Respiratory:			Abdomen:		
Appliances	Y	N	Symmetrical breath sounds	Y	N	Masses	Y	N
Missing/loose teeth	Y	N	Wheezes	Y	N	Organomegaly	Y	N
Caries needing treatment	Y	N	Cardiovascular:					
Enlarged lymph nodes	Y	N	Murmur	Y	N			
Skin - infectious lesions	Y	N	Irregularities	Y	N			
Peripheral pulses equal	Y	N	Murmur with Valsalva	Y	N			

Any "YES" under Cardiovascular requires a referral to family doctor or other appropriate healthcare provider.

Musculoskeletal: (note any abnormalities)

Neck:	Y	N	Elbow:	Y	N	Knee/Hip:	Y	N	Hamstrings:	Y	N
Shoulder:	Y	N	Wrist:	Y	N	Ankle:	Y	N	Scoliosis:	Y	N

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several Days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge.	0	1	2	3
Not being able to stop or control worrying.	0	1	2	3
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

RECOMMENDATIONS BASED ON ABOVE EVALUATION:

After my evaluation, I give my:

_____ Full Approval;

_____ Full approval; but needs further evaluation by Family Dentist ____; Eye Doctor ____; Family Physician _____; Other ____;

_____ Limited approval with the following restrictions: _____;

_____ Denial of approval for the following reasons: _____.

_____ _____/_____/_____

MD/DO/DC/Advanced Registered Nurse Practitioner/Physician's Assistant **Date**