Sports Participation Medical History (To be completed by Parent/Guardian)

Name:_____ Grade:___ Age:_____ Date:_____

Dear Parents: We want to assure, as well as possible, your child's safety for sport's participation. Please complete the following medical history about your child:

1: Has he/she had any serious illness or injury since their last regular or sport physical exam? __No __Yes

2: Have any family members under age 50 had a heart attack, heart problems, or died suddenly of causes other than an accident? __No __Yes

3: Have he/she ever been told they have a heart murmur, high blood pressure, extra heart beats, or a heart abnormality? __No __Yes

4: Is he/she missing any organs (eye, kidney, spleen, testicle, etc.)? __No __Yes

5: Has he/she ever had chest pain, fainting, or dizziness with exercise? __No __Yes

6: Has he/she ever "passed out", been "knocked out"(concussion), had trouble with heat exhaustion, or had seizures(convulsions)? __No __Yes

7: Is he/she on any regular medications, supplements, or performance enhancing medicines? __No __Yes

8: Does he/she have to stop while running twice around a standard track (400 meters / *a* mile)? __No __Yes

9: Other than a minor flu or other common medical illness, has he/she ever had an illness, injury or condition that:

- A: Required hospitalization, emergency room treatment, or x-ray> __No __Yes
- B: Required an operation? __No __Yes
- C: Lasted longer than a week? __No __Yes
- D: Caused you to miss a game or practice? __No __yes
- E: Is related to allergies (asthma, hay fever, hives, medicine)? __No __Yes

10: Does he/she wear glasses, contacts, have false teeth or use other medical or protective appliances? __No __Yes

11: Are you concerned about his/her weight? (or weight loss for sport?) __No __Yes

12: (Female only) Are her periods regular? Does she have menstrual problems? __No __Yes

Further Information on "Yes" Answers:

Your signature gives permission to allow our school physician to perform the physical exam, free of charge. (Signature)_____

Sports Exam (to be completed by MD/CNP/PA)

Name:_____ Date:_____

Hgt: ___ Wgt: __ BMI:__ Pulse: Resting: ___ Exercise:___ Recovery: ___ BP: ___/___

Vision screen done ___ Hearing screen done __

	N	Dental: N		N	Stage:
Skin			Abdomen		
Eyes			Liver		
Mouth			Spleen		
Nose			Genit.		
Neck			Tanner		
	N			N	
Chest			Ortho.		Scoliosis: N
Heart			Spine		
Pulses			Upper Ex		
Lungs			Lower Ex		

Summary

1. Full Participation ___
2 Limited Participation ___ Type
3 Needs Further Evaluation ___ Type
4 No Participation ___

_____

Signature: MD/CNP/PA

Classification of Sports

Strenuous			Moderately Strenuous	Non-strenuous
Contact	**Limited Contact**	**Non-contact**		
Football Ice Hockey Lacrosse(boys) Rugby Wrestling	Basketball Field Hockey Lacrosse(girls) Soccer Volleyball Gymnastics Skiing	Crew Cross country Fencing Swimming Tennis Track+Field Water polo	Badminton Baseball Golf Table Tennis Curling	Archery Bowling Riflery

School Nurse review/concerns: