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...)
- 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. Concussion/knocked out?
- Yes No 7. Knee, ankle or neck injuries?
- Yes No 8. Broken bone or dislocation?
- Yes No 9. Heat exhaustion/sun stroke?
- Yes No 10. Fainting or passing out?

Does the student:

- Yes No 11. Have any allergies?
- 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?

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

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 - PHYSICAL EXAM

Height ______________ Weight ______________ Pulse ______________ Blood Pressure ______________

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

L R L R

Mouth: Appliances: Y N; Missing/loose teeth: Y N; Caries in need of treatment: Y N

Skin: Any infectious lesions? Y N

Respiratory: Symmetrical breath sounds: Y N; Wheezes: Y N

Cardiovascular: Rate ______ Irregularities: Y N

Murmur: Y N Murmur with valsalva: Y N

Peripheral pulses equal: Y N

Abdomen: Masses: Y N; Splenomegaly: Y N; Hepatomegaly: Y N

Genitourinary: Inguinal hernia: Y N; Testicles descended bilaterally: Y N

Musculoskeletal: (note any abnormalities)

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

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 Date ____/____/____

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