Medical Examination & Medical History Consent Form

(Parent/Legal Guardian)

Please complete the following information:

Student Athlete Name: *(Last, first, MI)*		
DOB:	Age:	Grade:
Mailing Address:		
Physical Address:		
Parent/Guardian:		

SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN ***(CHECK ALL THAT APPLY)***

☐ Baseball	☐ Basketball	☐ Cheer/Drill	☐ Cross Country
☐ Football	☐ Golf	☐ Soccer	☐ Softball
☐ Track	☐ Volleyball	☐ Wrestling	☐ Other_____

_____ _____

Athlete (Print) Athlete Signature/Date

_____ _____

Parent/Guardian (Print) Parent/Guardian Signature/Date

Please answer all health history questions on the following page **PRIOR** to your visit to the doctor. Please complete the student-athlete's personal information on each page and return the entire packet to the school's Athletic Department.

ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM (Parent/Legal Guardian)

Part A: Health History Form ***Please use the back of the form if necessary for explanations.**

Student-Athlete Name:_____ Gender: _____ DOB: _____

1. Has a doctor ever denied or restricted your participation in sports for any reason? ___Yes____No
2. Do you have an ongoing medical condition (i.e. asthma, diabetes, high blood pressure)? ___Yes____No
3. Are you currently taking any prescription or over the counter medication? ___Yes____No
4. Do you have any allergies to medicines, pollen, foods or stinging insects? If yes, please circle
5. Have you ever become dizzy or passed out during or after exercise? ___Yes____No
6. Have you had chest pain or shortness of breath during or after exercise? ___Yes____No
7. Do you get more tired than your friends do during exercise? ___Yes____No
8. Has a doctor ever told you that you have high blood pressure? ___Yes____No
9. Has a doctor ever told you that you have a heart murmur or "heart trouble"? ___Yes____No
10. Do you have difficulty breathing during or after exercise? ___Yes____No
11. Has a doctor ever told you that you have asthma or allergies? ___Yes____No
12. Do you have a cough that doesn't go away or wheeze or have difficulty breathing during or after exercise? ___Yes____No
13. Have you ever used an inhaler or taken asthma medicine? ___Yes____No
14. Have you had a knocked out or passed out after being hit by an object? ___Yes____No
15. Have you ever had a concussion or hit in the head or after being hit in head complained of: Headache, dizzy spells, feeling confused or difficulty concentrating or forgetful? (please circle one or more)
16. Have you ever been unable to move your arms or legs after being hit or fallen down? ___Yes___No
17. Have you every had a seizure or convulsions? ___Yes___No
18. Do you have headaches? If yes, how often?_____ Or Have headaches with exercise? If yes, how often? _____
19. Have you ever had tingling or numbness or weakness in your arms, hands, legs or feet? ___Yes____No
20. While exercising have you ever had severe muscle cramps or muscle tightness? ___Yes____No
21. Have you ever suffered from heat illness/heat stroke/passed out while exercising in the heat?___Yes _No When_____
22. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)? ___Yes____No
23. Has anyone in your family died for no apparent reason? ___Yes____No
24. Has anyone in your family had a heart problem? ___Yes____No Heart Attack? ___Yes____No
25. Has a family member or relative died of heart problems or sudden death before the age of 50? ___Yes____No
26. Have you ever felt like your heart was racing or skipped heartbeats? ___Yes____No
27. Have you ever had an injury like a sprain, pulled muscle or torn ligament or tendonitis that has caused you to miss a game or practice? Please list:_____ ___Yes____No
28. Have you had any broken or fractured _ones or dislocated joints? ___Yes____No
    If Yes, Please list:_____
29. Have you ever had bone or joint injury that required injection, x-rays, MRI, CT? (Please circle one or more)
30. Have you ever had Surgery?___Yes____No When?_____Where? _____
31. Have you ever had to go to: Physical Therapy or Rehabilitation ___Yes___No
32. Have you ever been fitted with a brace, splint, cast, crutches?____Yes____No (If yes, please circle one or more)
33. Have you ever had a stress fracture?_ Yes _ No. If yes please list location_____
34. Do you regularly wear an Ace wrap or brace or splint? ___Yes____No
35. Were you born without or missing a kidney, an eye or testicle or any other organ? ___Yes____No
36. Have you had a severe viral infection such as infectious mononucleosis (mono) or chronic fatigue? ___Yes____No
37. Do you have any rashes, or acne or other skin problems? ___Yes____No
38. Have you had a herpes infection? ___Yes _ _No Hepatitis? _Yes_____No
39. Have you had any problems with your eyes or vision? ___Yes____No
40. Do you wear glasses or contacts? ___Yes____No
41. Do you wear protective eyewear such as goggles or a face shield? ___Yes____No
42. Are you trying to gain or lose weight?
43. Have you ever taken anything to help you build muscle or lose weight? If yes, please list_____
44. Has anyone recommended you change your weight or eating habits? ___Yes____No
45. Do you have concerns that you would like to discuss with your healthcare provider? ___Yes____No

Females Only:

46. Have you had a monthly menstrual period? ___Yes____No
47. How old were you when you had your first menstrual period or "monthly?_____
48. Are your menstrual periods 'regular" or every 30 days? Yes No
    More frequent?___Yes____No Less frequent? Yes No
49. Have you ever missed a period? Yes No

_____ _____

Parent/Legal Guardian (Print) Parent/Legal Guardian Signature/Date

_____ _____

Primary Care Provider (Print) Primary Care Provider Signature/Date

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM **(Physician Only)**
Part B: Physical Examination

TO BE COMPLETED BY THE EXAMINING PHYSICIAN OR PROVIDER-PLEASE COMPLETE BOTH PAGES

Student-Athlete Name:_____ Gender: _____ DOB: _____

BMI%ile____ Pulse ____ Blood Pressure___/___ Blood Pressure%ile ____ Height ____ Weight ____
(Recheck if elevated___/___ (per NIH guidelines)

Vison: R20/___L20/____ Corrected: Y / N Does Athlete wear contacts? Y / N Pupils: Equal ____ Unequal ____

Does Athlete require eye protection while playing? Y / N

Medical	**Normal (Please Circle)**		**Abnormal Findings/Comments**
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph Nodes	YES	NO	
Heart (Auscultation should be done supine and standing-abnormal findings require referral of further evaluation)	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment (Incl. liver, spleen)	YES	NO	
Genitourinary	YES	NO	
Skin	YES	NO	
Musculoskeletal	**Normal (Please Circle)**		**Abnormal Findings/Comments**
Neck	YES	NO	
Back	YES	NO	
Shoulder/Arm	YES	NO	
Elbow/Forearm	YES	NO	
Wrist/Hand/Fingers	YES	NO	
Hip/Thigh	YES	NO	
Knee	YES	NO	
Leg/Ankle	YES	NO	
Foot/Toes	YES	NO	

Notes:_____

_____

_____

_____ _____

Provider's Signature Date

Part B: Clearance Form (Physician Only)

Athlete Name: _____ Gender: _____ DOB: _____

SAMPLES OF CLASSIFICATION OF SPORT BY CONTACT

Contact/Collision	Limited Contact	Non-Contact/Strenuous	Non-Contact/Non Strenuous
Rodeo	Baseball	Discus	Bowling
Football	Cheerleading	Javelin	Golf
Soccer	High Jump	Shot Put	
Wrestling	Softball	Running/Cross Country	
Basketball	Volleyball	Strength Training	
		Track	

Student-Athlete MAY participate in the following types of sports (Check all applicable):

☐ STUDENT CLEARED FOR ALL FORMS OF ATHLETICS

☐ Student Cleared for Participation with no restrictions

☐ Student Cleared with the following restrictions: _____

☐ Student Cleared for Participation PENDING: _____

☐ Student **NOT** Cleared for Participation (Reason): _____

Student-Athlete Emergency Information

Allergies: _____ History of Anaphylaxis? ☐ Yes ☐ No

Immunizations Current? ☐ Yes ☐ No Last Tetanus Immunization: _____

Significant Medical History Information/Current Medical Conditions (*Please include any history of asthma, hypertension, previous head injury, unequal pupil size, etc.).*

Physical Performed by: _____ Phone: _____

Address: _____

Provider's Signature: _____ Date: _____