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. – VITAL SIGNS

Height ____________ Weight ____________ Pulse ____________ Blood Pressure ____________

Visual acuity: Uncorrected ______/______ (L / R); Corrected ______/______ (L / R); 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:			Genitourinary (males only):		
Enlarged lymph nodes	Y	N	Murmur	Y	N	Inguinal hernia	Y	N
Skin - infectious lesions	Y	N	Irregularities	Y	N	Bilaterally descended testicles	Y	N
Peripheral pulses equal	Y	N	Murmur with Valsalva	Y	N			

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

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 ____/____/____