



Page 1 of 2

Age:Grade:Sex: This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered. Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge. Parent's Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or do the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports as a Physician's Directions: We recommend carefully reviewing these questions and clarifying any "Yes" or "Unsure" answers. Explain "Yes" or "Unsure" answers below in the space provided or on an attached separate sheet. Yes No 1. Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? Please List: 1. Is the athlete presently taking any medications or pills? 3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)? 4. Does the athlete have the sickle cell trait? 5. Has the athlete ever had a heat injury, been knocked out, or had a concussion? 6. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities? 7. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities? 9. Has the athlete ever fainted or passed out AFTER exercise? 9. Has the athlete ever fainted or passed out AFTER exercise? 9. Has the athlete ever had one diagnosed with exercise-induced asthma? 10. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"? 13. Has a doctor ever otold the athlete that they have a heart infection? 14. Has a doctor ever told the athlete that they have a heart infection? 15. Has the athlete ever had a seizure or been diagnosed with an unexpla	lon't kr
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or joints? (check appropriate boxes below) 1 Head	
Forearm - Snin/Call - Back - Wrist - Ankle - Hand - Foot - Other	
20. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	
21. Has the athlete ever been hospitalized or had surgery?	
22. Has the athlete had a medical problem or injury since their last evaluation? 23. Place a check beside each statement that applies to the student-athlete, elaborate in the space below	
23. Place a check beside each statement that applies to the student-athlete, elaborate in the space below 1. Has the student-athlete had little interest or pleasure in doing things?	
☐ 1. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row?	
☐ 1. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down?	
☐ 1. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?	
FAMILY HISTORY	
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death	
syndrome [SIDS], car accident, drowning)?	
25. Has any family member had unexplained heart attacks, fainting or seizures?	
26. Does the athlete have a father, mother or brother with sickle cell disease?	
xplain "Yes" or "Unsure" answers:	
	
signing below, I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the	
owledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in s	
ignature of parent/legal custodian:	

(Approved use for 2019-2020 School Year)

_____ Date: _____

Signature of student-athlete:

udent-Athlete's Na	me:			Age:	Dat	te of Bir	th:
eight:	_ Weight:	BP: _	(_%ile) /	(_%ile)	Pulse:
ision: R 20/	_ L 20/	Corrected: Y	N				
Physical Examination	n (Below Must be C	ompleted by Licer	nsed Physician	, Nurse Prac	ctitioner or F	Physicia:	n Assistant)
	Th	ese are required	d elements fo	r all exam	inations		
	NORMAL	ABNORMAL			ABNORMAL	FINDING	S
PULSES							
HEART							
LUNGS							
SKIN							
NECK/BACK							
SHOULDER							
KNEE							
ANKLE/FOOT							
Other Orthopedic							
Problems							
	Oı	otional Examination	Elements - Shou	ıld be done if	history indica	tes	
HEENT							
ABDOMINAL							
GENITALIA (MALES)							
HERNIA (MALES)							
	er completing evaluat						
☐ D. Not cleare	□ No	n-contact			ately strenuo	us	Non-strenuous
ie to:							
ditional Recommendat	tions/Rehab Instructio	ons:					
ame of Physician/Exten	der:						
				DO PA NE	• (Signature	and circle	e of designated degree required)
							2019-2020 school year
dress of medical office						_	s Stamp Below -
fice Phone:							
*** The following are consider	red disqualifying until appr	inriate medical and paren	ntal releases are obtai	ned: nost-operat	ive clearance acu	ıta infaction	as obvious growth retardation

(*** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, uncontrolled diabetes, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or Stage 2 hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of uncontrolled seizures, absence of/ or one kidney, eye, testicle or ovary, etc.)



