**SPORTS PARTICIPATION MEDICAL EXAMINATION**

To the Health Care Provider – Please complete and sign *Mandated Screening/Test under CT State Law

Name:_____ Date of Birth: _____**Date of Exam:** _____

| General Exam | Normal | Abnormal Findings |
|---|---|---|
| Appearance | | |
| Skin | | |
| Heent | | |
| Respiratory | | |
| Cardiovascular Arrhythmia: Murmur: | | |
| Abdomen | | |
| Neurological | | |
| Genitalia (hernia) | | |
| Physical Maturity (Tanner Stage) 1 2 3 4 5 | | |

Height:*_____Weight:*_____
Blood Pressure:*_____Pulse: _____
HCT/HGB:*_____
Urinalysis: ___Protein:__Blood:__Glucose:_____
Visual Acuity:*_____ Right_____Left
Corrected to_____Right_____Left
Hearing:*_____
Gross Dental:*_____

Body Fat_____%
Cholesterol _____%

Last Tetanus Booster Date:_____
Last Measles(MMR) Booster Date:_____
HBV 1_____2_____3_____
Varicella Disease Date_____OR
Varicella Immunization 1_____2_____

**Chronic Disease Assessment***

Yes No
__ __ Asthma:__mild__moderate__severe
__exercise induced__unclassified
__ __ Diabetes__Type I__Type II

TB: IN HIGH RISK GROUP ___YES ___ NO

| TB TEST | DATE | RESULTS |
|---|---|---|

__ __ Seizure Disorder _____
__ __ Anaphylactic Reaction:__ food __ insect __ latex
__ __ Other: Please specify_____

Musculoskeletal Evaluation to include range of motion, strength, flexibility

| | Normal | Abnormal Findings |
|---|---|---|
| Neck | | |
| Spine | | |
| **Postural*** | | Min. ____Slight____Mod.____Marked____ |
| Shoulders | | |
| Arms/Hands | | |
| Hips | | |
| Thighs | | |
| Knees | | |
| Ankles | | |
| Feet | | |

**Comments and Recommendations**

Weight loss/gain _____Medications _____
Strengthening _____Special Equipment_____
Stretching _____Bracing/Taping _____
Conditioning (endurance) _____ Comments_____

**•I certify that on this date I have examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed:**

_____ _____ _____
Signature of Physician, RN, APRN,PA Telephone Provider Print or Stamp

# Sports Participation Health Record

This evaluation is to determine readiness for sports participation. This must be completed by a parent and student before being brought to the Doctor's office.

Name:_____Age:_____Sex:_____School_____
Address:_____Phone:_____Grade:_____
Sports being played (1)_____(2)_____(3)_____

## Medical History

**(To be completed by student and parent/guardian)**

1.Do you have any allergies?(Drugs, Food, Insect Stings, etc.)
_____yes; List_____ _____No
2. Are you currently taking any drugs or medications including steroids or protein supplements(Daily or occasionally)
_____yes; List_____ _____No
3. Are you presently being treated for any condition by a physician or other health care professional?
_____yes; Explain_____ _____No
4. Have you ever been advised by a doctor not to participate in any sport?
_____yes; Explain_____ _____ No
5. Do you have any chronic conditions, disorders or diseases? Check those applicable or…._____ No

_____Asthma ____Bleeding Disorders ____Diabetes ___Epilepsy(Seizures)
_____Hepatitis(liver disease) ____Hypertension(High Blood Pressure) ____Sickle Cell Anemia ___Other_____
_____Mononucleosis-Yr __ ____Kawasaki Disease ____Disability (describe)_____

*Please Check where applicable if you have or have had any of the following:*

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Head injury, concussion, or been unconscious | ___ | ___ | Eye injury or retinal detachment | ___ | ___ |
| If yes, how many times_____ | | | Blurred vision or vision in one eye only | ___ | ___ |
| Headaches more than once a week | ___ | ___ | Wear glasses or contact lenses | ___ | ___ |
| Lack of feeling or numbness in any part of the body | ___ | ___ | Hearing loss or impairment in one or both ears | | |
| Heat exhaustion or heat stroke | ___ | ___ | Tubes in ears or perforated ear drum | ___ | ___ |
| Difficulty running ½ mile without stopping | ___ | ___ | False teeth, caps or braces | ___ | ___ |
| Chest pain, dizziness or passing out during exercise | ___ | ___ | Nose bleeds for no reason | ___ | ___ |
| Coughing, wheezing or gasping for breath with exercise or cold weather | ___ | ___ | Bruising easily or taking a long time to stop bleeding when cut | ___ | ___ |
| Smoke cigarettes or chew tobacco | ___ | ___ | Diarrhea more than once a week | ___ | ___ |
| Heart problem, murmur or arrhythmia | ___ | ___ | Black or bloody bowel movements (stools) | ___ | ___ |
| Family member with a heart attack under age 50 | ___ | ___ | Kidney disease or dark, brown or bloody urine | ___ | ___ |
| Loss or gain of more than 10 lbs. in last year | ___ | ___ | Less than two kidneys or in males, two testicles | ___ | ___ |
| Special diet for medical reasons | ___ | ___ | Lump(s) in arm pit or groin | ___ | ___ |
| ***For female participants*** | | | Rash or skin problem | ___ | ___ |
| Absent or irregular monthly periods | ___ | ___ | Neck, spine or low back injury or pain | ___ | ___ |
| Disabling cramps with your menstrual periods | ___ | ___ | | | |

Have you ever been hospitalized for medical or surgical reasons? __ __
If yes, provide the following information:

| **Reason** | **Year** | **Hospital** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more.

| Injured Area (knee, Hamstring, Neck, Shin, etc.) | Year | Side (R/L) | Type (Fracture, Sprain, Swelling, Pinched Nerve, etc. | Resolved Yes | Resolved No |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

**Student and Parent or Guardian**:
We hearby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

_____ _____ _____ _____
Student Signature Date Parent/Guardian Signature Date