**MEDICAL EXAMINATION** – To Be Completed By Medical Doctor or his designee

NAME _____ DATE OF BIRTH _____

## GENERAL EXAM

| | Normal | Abnormal Findings |
|---|---|---|
| APPEARANCE | | |
| SKIN | | |
| HEENT | | |
| RESPIRATORY | | |
| CARDIOVASCULAR | | |
| | Arrhythmia | |
| | Murmur | |
| ABDOMEN | | |
| SPINE | | |
| 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:_____

BODY FAT **(Optional)** = _____ %
CHOLESTEROL **(Optional)** = _____

LAST TETANUS BOOSTER Date:_____
LAST MEASLES (MMR) BOOSTER Date:_____
OTHER IMMUNIZATIONS_____ Date:_____

SUMMARY: _____

## ORTHOPEDIC EXAM

**MUSCULOSKELETAL EVALUATION** TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

| | Normal | Abnormal Findings |
|---|---|---|
| NECK | | |
| SPINE | | |
| SHOULDERS | | |
| ARMS/HANDS | | |
| HIPS | | |
| THIGHS | | |
| KNEES | | |
| ANKLES | | |
| FEET | | |

## RECOMMENDATIONS

WEIGHT LOSS/GAIN _____ MEDICATIONS _____
STRENGTHENING _____ SPECIAL EQUIPMENT _____
STRETCHING _____ BRACING/TAPING _____
CONDITIONING (Endurance) _____

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 below:

_____

_____

_____M.D. _____ _____ _____
SIGNATURE OF MEDICAL DOCTOR DATE TELEPHONE MEDICAL DOCTOR (PRINT OR STAMP)

This form was developed and approved by: Connecticut Chapter, Committee on Sports Medicine – American Academy of Pediatrics
Connecticut Chapter, Committee on School Health – American Academy of Pediatrics
The Connecticut State Medical Society Committee on the Medical Aspects of Sports

# SPORTS PARTICIPATION HEALTH RECORD

**This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. *THIS SIDE MUST BE COMPLETED BY PARENT & 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 or 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's Disease _____ Handicap (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 if yes, how many times_____ | _____ | _____ | Eye injury or retinal detachment | _____ | _____ |
| | | | 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 a perforated eardrum | _____ | _____ |
| Difficulty running 1/2 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?** → → → → → → → → → → → → → → → → **YES** _____ **NO** _____

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 hereby 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 OR GUARDIAN SIGNATURE DATE