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 medication 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 _____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
Head injury, concussion, or been unconscious	☐	☐
If yes, how many times_____		
Headaches more than once a week	☐	☐
Lack of feeling or numbness in any part of the body	☐	☐
Heat exhaustion or heat stroke	☐	☐
Difficulty running ½ mile without stopping	☐	☐
Chest pain, dizziness or passing out during exercise	☐	☐
Coughing, wheezing, or gasping for breath with exercise or cold weather	☐	☐
Smoke cigarettes or chew tobacco	☐	☐
Heart problem, murmur or arrhythmia	☐	☐
Family member with a heart attack under age 50	☐	☐
Loss or gain of more than 10 lbs. in last year	☐	☐
Special diet for medical reasons	☐	☐
For female participants:		
Absent or irregular monthly periods	☐	☐
Disabling cramps with your menstrual periods	☐	☐

	YES	NO
Eye injury or retinal detachment	☐	☐
Blurred vision or vision in one eye only	☐	☐
Wear glasses or contact lenses	☐	☐
Hearing loss or impairment in one or both ears	☐	☐
Tubes in ears or a perforated eardrum	☐	☐
False teeth, caps, or braces	☐	☐
Nose bleeds for no reason	☐	☐
Bruising easily or taking a long time to stop bleeding when cut	☐	☐
Diarrhea more than once a week	☐	☐
Black or bloody bowel movements (stools)	☐	☐
Kidney disease or dark, brown or bloody urine	☐	☐
Less than two kidneys or, in males, two testicles	☐	☐
Lump(s) in arm pit or groin	☐	☐
Rash or skin problem	☐	☐
Neck, spine, or low back injury or pain	☐	☐

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