STAPLES HIGH SCHOOL SPORTS PARTICIPATION MEDICAL EXAMINATION

To be completed by the Physician, RN, APRN, or PA. This medical examination is valid for one calendar year from date of exam.*

Name_____ Date of Birth_____ ***Date of Exam*** _____

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

General Exam

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:_____

HBV 1_____2_____3_____

Chronic Disease Assessment

__Asthma__mild__moderate__severe
__exercise induced__unclassified
__Diabetes__Type I__Type II
__Anaphylactic reaction:__food__insect__latex
__Seizure disorder
__Other: Please specify_____

Orthopedic Exam

Musculoskeletal Evaluation: to include range of motion, strength, and flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Postural		Min. ____Slight____Mod.____Marked____
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 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:**

_____

_____ _____ _____

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

FORM A

STAPLES HIGH SCHOOL 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 physician'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)

***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 _ 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. The first is an example. Please attach another sheet if necessary.

Injured Area (Knee, Hamstring, Neck, Shin, etc.)	**Year**	**Side** (R/L)	**Type** (Fracture, Sprain, Swelling, Pinched Nerve, etc.	**Resolved** Yes	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