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 AND STUDENT HEALTH CENTER.**

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____ NO____
   LIST: _____
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally) YES_NO____
   LIST: _____
3. Are you presently being treated for any condition by a physician or other health care professional? YES____NO____
   EXPLAIN:_____
4. Have you ever been advised by a doctor not to participate in a sport? YES____ NO____
   EXPLAIN: _____
5. Do you have any chronic conditions, disorders or diseases? YES____ NO____ check those applicable

_____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 at 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 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	____	____
For female participants:			Lump(s) in arm pit or groin	____	____
Absent or irregular monthly periods	____	____	Rash or skin problem	____	____
Disabling cramps with your menstrual periods	____	____	Neck, spine or low back injury or pain	____	____

Have you ever been hospitalized for medical or surgical reason? 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 fo 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