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

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