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!*

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		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 ½ 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