

School & Sports Qualifying Screening Evaluation

Please Complete in Ink

Student Name _____
 Address: _____
 City/Zip: _____ Telephone: _____
 Date of Birth: _____ Age: _____ Male _____ Female _____
 Grade: _____ School: _____

School/Clinic: _____
 Address: _____
 Phone: _____

Revised 4/99

EXAMINATION

*Ht _____ Wt _____ BP _____ / _____ Pulse _____

Vision R _____ L _____

Hearing

kHz	0.25	0.5	1	2	3	4	6	8
R								
L								

*MEDICAL EXAM

(cross out if omitted) Normal Abnormal Comments

HEENT

Eyes _____
 Ears _____
 Nose _____
 Throat _____
 Dental _____
 Thyroid _____
 Nodes _____
 Lungs _____
 Heart/Murmurs _____
 Abdomen _____
 Genitalia (males) _____
 Hernia _____
 Skin _____
 Neck _____
 Upper Extremities _____
 Back/Spine _____
 Lower Extremities _____
 Neuro. _____

Labs (if required)

* UA dip: Ap _____ col _____ sp gr _____ pH _____ Pr _____ sug _____ Ket _____
 Bld _____ Bil _____ Uro _____ leuk _____ nit _____

Hgb: _____

Certification for Participation in Physical Education/Athletic Activities

I herewith certify that the student named above has been evaluated as indicated by the above record to be physically fit to participate in physical education activities and/or interscholastic athletics, except as noted below. Any exceptions or required modifications should be re-evaluated annually or as specified.

Modifications or exceptions: _____

Deferred pending further evaluation for _____

A copy of this form should go with this individual to all sporting activities.

Required medication: _____

Physician Signature: _____ Date: _____

I do not know of any existing physical condition or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities.

I hereby authorize release to the school nurse of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Signature _____ Date _____
 (Parent or Legal Guardian)

PLEASE COMPLETE PRIOR TO EXAMINATION

HISTORY

YES NO

- *1. Have you ever fainted? YES NO
 Have you ever fainted during exercise? YES NO
 Have you had chest pain during exercise? YES NO
- *2. Has anyone in your family died suddenly? YES NO
 Before age 35? _____ Before age 50? _____
 Cause: _____
- *3. Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury? YES NO
 If yes, how many times? _____
- *4. Have you ever had heat stroke or heat exhaustion? YES NO
- *5. Do you wheeze or cough during or after exercise? YES NO
 Do you have any history of asthma? YES NO
- *6. Do you have any allergies? (medications, bee sting, pollen, etc.) _____ YES NO
- *7. Any injuries since last exam? YES NO
 If yes, list injuries: _____
- *8. Do you take any medication? (include vitamins and nonprescription drugs) _____ YES NO
- *9. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? YES NO
10. Have you ever been hospitalized? YES NO
 Have you ever had surgery? YES NO
 If yes, explain _____
11. If female, when was your first menstrual period? _____
 When was your most recent menstrual period? _____
12. In the last year, what was your:
 Lowest weight _____ Your highest weight _____
 What do you think is your ideal weight? _____
13. Immunizations: Last tetanus _____
 Measles, Mumps, German Measles (MMR) (1) _____ (2) _____
 Hepatitis B (1) _____ (2) _____ (3) _____
- *14. Circle any of the following you have had:
- | | |
|-----------------------------------|--------------------------------|
| Abnormal bleeding/bruising | Anemia |
| Broken bones/stress fracture | Diabetes |
| Dislocation (shoulder, etc.) | Hearing Impairment |
| Heart murmur/palpitations | Hepatitis/jaundice |
| High blood pressure | Loss of eye sight |
| Rheumatic fever | Scoliosis (curvature of spine) |
| Seizures | Sickle-cell disease |
| Single organs (kidney, eye, etc.) | Undescended testicle |
- Other _____
 I have had none of the above problems.
15. Do you use seat belts on a regular basis? YES NO
16. Do you use tobacco or alcohol? YES NO
17. Are there any concerns you would like to discuss? YES NO
 (Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other)
- * Must be answered for participation in athletics

Additional Comments: _____

Student's Signature _____ Date _____

Return this form to your School Health Office