

# 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 4/89

## PLEASE COMPLETE PRIOR TO EXAMINATION

- HISTORY**
- |   | YES                            | NO                       |
|---|--------------------------------|--------------------------|
| *1. Have you ever fainted?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| Have you ever fainted during exercise?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| Have you had chest pain during exercise?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| *2. Has anyone in your family died suddenly?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| 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?   | <input type="checkbox"/>       | <input type="checkbox"/> |
| If yes, how many times? _____   |                                |                          |
| *4. Have you ever had heat stroke or heat exhaustion?   | <input type="checkbox"/>       | <input type="checkbox"/> |
| *5. Do you wheeze or cough during or after exercise?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| Do you have any history of asthma?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| *6. Do you have any allergies? (medications, bee sting, pollens, etc.) _____  | <input type="checkbox"/>       | <input type="checkbox"/> |
| *7. Any injuries since last exam?   | <input type="checkbox"/>       | <input type="checkbox"/> |
| If yes, list injuries: _____  |                                |                          |
| *8. Do you take any medication? (include vitamins and nonprescription drugs) _____  | <input type="checkbox"/>       | <input type="checkbox"/> |
| *9. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?                                      | <input type="checkbox"/>       | <input type="checkbox"/> |
| 10. Have you ever been hospitalized?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| Have you ever had surgery?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| 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 _____   |                                |                          |
| 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 _____   |                                |                          |
| <input type="checkbox"/> I have had none of the above problems.   |                                |                          |
| 15. Do you use seat belts on a regular basis?   | <input type="checkbox"/>       | <input type="checkbox"/> |
| 16. Do you use tobacco or alcohol?  | <input type="checkbox"/>       | <input type="checkbox"/> |
| 17. Are there any concerns you would like to discuss? (Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other) | <input type="checkbox"/>       | <input type="checkbox"/> |
| * Must be answered for participation in athletics   |                                |                          |

Additional Comments: \_\_\_\_\_

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

## 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.            | _____ | _____ |

#### UAs (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)