

# STAPLES HIGH SCHOOL SPORTS PARTICIPATION MEDICAL EXAMINATION

*To be completed by the Physician, RN, APRN, or PA. \* This medical examination is valid for one calendar year from date of exam.*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ **Date of Exam** \_\_\_\_\_

### General Exam

	Normal	Abnormal Findings
Appearance		
Skin		
Heart		
Respiratory		
Cardiovascular		
		Arrhythmia
		Murmur
Abdomen		
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner Stage) 1 2 3 4 5		

Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_  
 HCT/HGB \_\_\_\_\_  
 Urinalysis \_\_\_ Protein \_\_\_ Blood \_\_\_ Glucose \_\_\_  
 Visual Acuity \_\_\_\_\_ Right \_\_\_\_\_ Left  
                     Corrected to \_\_\_\_\_ Right \_\_\_\_\_ Left  
 Hearing \_\_\_\_\_

Body Fat (Optional) \_\_\_\_\_ %  
 Cholesterol (Optional) \_\_\_\_\_

Last Tetanus Booster  
 Date: \_\_\_\_\_  
 HBV 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

### Chronic Disease Assessment

\_\_\_ Asthma \_\_\_ mild \_\_\_ moderate \_\_\_ severe  
                     \_\_\_ exercise induced \_\_\_ unclassified  
 \_\_\_ Diabetes \_\_\_ Type I \_\_\_ Type II  
 \_\_\_ Anaphylactic reaction: \_\_\_ food \_\_\_ insect \_\_\_ latex  
 \_\_\_ Seizure disorder  
 \_\_\_ Other: Please specify \_\_\_\_\_

### Orthopedic Exam

Musculoskeletal Evaluation: to include range of motion, strength, and flexibility

	Normal	Abnormal Findings
Neck		
Spine		
<b>Postural</b>		Min. ___ Slight ___ Mod. ___ Marked ___
Shoulders		
Arms / Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

### Recommendations

Weight loss/gain \_\_\_\_\_ Medications \_\_\_\_\_  
 Strengthening \_\_\_\_\_ Special Equipment \_\_\_\_\_  
 Stretching \_\_\_\_\_ Bracing/Taping \_\_\_\_\_  
 Conditioning (endurance) \_\_\_\_\_

**\*I certify that on this date I have examined this student and that, on the basis of the examination requested by school authorities and the student's medical history, as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:**

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Signature of Physician, RN, APRN, PA \_\_\_\_\_ Telephone \_\_\_\_\_ Provider Print or Stamp \_\_\_\_\_

**STAPLES HIGH SCHOOL SPORTS PARTICIPATION HEALTH RECORD**

*This evaluation is to determine readiness for sports participation. This must be completed by a parent and student before being brought to the physician's office.*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ School \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Sports being played (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

**Medical History**

**(To be completed by student and parent/guardian)**

- Do you have any allergies?(drugs, food, insect stings, etc.)  
 \_\_\_\_\_ yes; List \_\_\_\_\_ No
- Are you currently taking any drugs or medications including steroids or protein supplements (daily or occasionally)  
 \_\_\_\_\_ yes; List \_\_\_\_\_ No
- Are you presently being treated for any condition by a physician or other health care professional?  
 \_\_\_\_\_ yes; Explain \_\_\_\_\_ No
- Have you ever been advised by a doctor not to participate in any sport?  
 \_\_\_\_\_ yes; Explain \_\_\_\_\_ No
- Do you have any chronic conditions, disorders or diseases? Check those applicable or.... No  
 \_\_\_\_\_ Asthma \_\_\_\_\_ Bleeding Disorders \_\_\_\_\_ Diabetes \_\_\_\_\_ Epilepsy (Seizures)

**Please check where applicable if you have or have had any of the following:**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Head injury, concussion, or been unconscious If yes, how many times _____	___	___	Eye injury or retinal detachment	___	___
Headaches more than once a week	___	___	Blurred vision or vision in one eye only	___	___
Lack of feeling or numbness in any part of the body	___	___	Wear glasses or contact lenses	___	___
Heat exhaustion or heat stroke	___	___	Hearing loss or impairment in one or both ears	___	___
Difficulty running _____ mile without stopping	___	___	Tubes in ears or perforated ear drum	___	___
Chest pain, dizziness or passing out during exercise	___	___	False teeth, caps or braces	___	___
Coughing, wheezing or gasping for breath	___	___	Nose bleeds for no reason	___	___
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	___	___
<b>For female participants</b>			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?..... \_\_\_ \_\_\_

If yes, provide the following information:

<b><u>Reason</u></b>	<b><u>Year</u></b>	<b><u>Hospital</u></b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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. The first is an example. Please attach another sheet if necessary.

<b><u>Injured Area</u></b>	<b><u>Year</u></b>	<b><u>Side</u></b>	<b><u>Type</u></b>	<b><u>Resolved</u></b>
<small>(Knee, Hamstring, Neck, Shin, etc.)</small>		<small>(R/L)</small>	<small>(Fracture, Sprain, Swelling, Pinched Nerve, etc.)</small>	<small>Yes No</small>
_____	_____	_____	_____	___ ___
_____	_____	_____	_____	___ ___
_____	_____	_____	_____	___ ___

**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/Guardian Signature                                      Date