

## EAST CATHOLIC HIGH SCHOOL SPORTS PARTICIPATION HEALTH FORM

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. *THIS PART 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, Foods, 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	_____	_____
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 1/2 mile without stopping	_____	_____	Tubes in ears or a perforated eardrum	_____	_____
Chest pain, dizziness or passing out during exercise	_____	_____	False teeth, caps or braces	_____	_____
Coughing, wheezing or gasping for breath with exercise or cold weather	_____	_____	Nose bleeds for no reason	_____	_____
Smoke cigarettes or chew tobacco	_____	_____	Bruising easily or taking a long time to stop bleeding when cut	_____	_____
Heart problem, murmur or arrhythmia	_____	_____	Diarrhea more than once a week	_____	_____
Family member with a heart attack under age 50	_____	_____	Black or bloody bowel movements (stools)	_____	_____
Loss or gain of more than 10 lbs. in last year	_____	_____	Kidney disease or dark, brown or bloody urine	_____	_____
Special diet for medical reasons	_____	_____	Less than two kidneys or, in males, two testicles	_____	_____
<i>For female participants:</i>			Lump(s) in arm pit or groin	_____	_____
Absent or irregular monthly periods	_____	_____	Rash or skin problems	_____	_____
Disabling cramps with your menstrual periods	_____	_____	Neck, spine or low back injury or pain	_____	_____

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)	HOSPITAL (Fracture, Sprain, Swelling, Pinched Nerve, etc.)	RESOLVED	
				YES	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 \_\_\_\_\_

**MEDICAL EXAMINATION – To Be Completed By Medical Doctor or his designee**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**GENERAL EXAM**

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
		Arrhythmia
		Murmur
ABDOMEN		
SPINE		
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: \_\_\_\_\_  
 LAST MEASLES (MMR) BOOSTER DATE: \_\_\_\_\_  
 OTHER IMMUNIZATIONS \_\_\_\_\_ DATE: \_\_\_\_\_

SUMMARY: \_\_\_\_\_

**ORTHOPEDIC EXAM**

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS.HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

**RECOMMENDATIONS**

WEIGHT LOSS/GAIN \_\_\_\_\_  
 STRENGTHENING \_\_\_\_\_  
 STRETCHING \_\_\_\_\_  
 CONDITIONING (Endurance) \_\_\_\_\_  
 MEDICATIONS \_\_\_\_\_  
 SPECIAL EQUIPMENT \_\_\_\_\_  
 BRACING/TAPING \_\_\_\_\_

I certify that on this date I have examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me. This is good for the school year of \_\_\_\_\_ unless voided by any serious injury or accident. If voided, it will be the responsibility of the student to get updated medical information from his/her physician before resuming participation in competitive sports. I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:

\_\_\_\_\_  
 \_\_\_\_\_ M.D.  
 SIGNATURE OF MEDICAL DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_ MEDICAL DOCTOR (PRINT OR STAMP) \_\_\_\_\_