

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/GUARDIAN AND PRESENTED TO PHYSICIAN AT THE TIME OF EXAM.**

NAME: _____ AGE: _____ SEX: _____ SCHOOL _____
 ADDRESS: _____ PHONE: _____ GRADE: _____
 SPORTS BEING PLAYED (1) _____ (2) _____ (3) _____
 Health Insurance Company: _____ Policy Number: _____

MEDICAL HISTORY

(To be completed by student and parent or guardian)

1. Do you have any allergies? (drugs, food, insect sting, etc.)
 No Yes If yes, list _____
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally?)
 No Yes If yes, list _____
3. Are you presently being treated for any condition by a physician other health care professional?
 No Yes If yes, list _____
4. Have you ever been advised by a doctor not to participate in any sport?
 No Yes If yes, list _____
5. Do you have any chronic conditions, disorders or diseases? Check those applicable or none

Asthma	Bleeding Disorders	Kawasaki's disease	Handicap (Describe: _____)
Diabetes	Mononucleosis - YR _____	Epilepsy (seizures)	
Hepatitis (liver disease)	Hypertension (High blood pressure)	Sickle Cell Anemia	Other _____

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

	YES	NO		YES	NO
Head injury, concussion or being 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			Tube 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 bleed for no reason		
Smoke cigarettes or chew tobacco			Bruising easily or taking a long time to stop bleeding when cut		
Heart problems, 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		
For female participants: Absent or irregular monthly periods			Lump(s) in arm pit or groin		
Disabling cramps with your menstrual periods			Rash or skin problem		
			Neck, spine or low injury or pain		

Have you ever been hospitalized for medical or surgical reasons? No Yes 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)	YES	NO

STUDENT AND OR GUARDIAN: We hereby state that we have reviewed this medical history and found the information above to be correct to the best of our knowledge.

Student Signature _____ Date _____ Parent or Guardian Signature _____ Date _____

FARMINGTON PUBLIC SCHOOLS SPORTS PHYSICAL EXAM FORM

NAME: _____ Birth Date: _____ Date of Exam: _____

This form may be used in lieu of the state form for the required 6th and 10th grade physical exams. NOTE: Items with an asterisk (*) indicate mandated screenings under Connecticut State Law for these exams.

A physical exam is valid for one year for interscholastic athletics. If the exam expires during a sports season, a new one is required before a student may continue participation in practice or play.

Screening/Test Results

NOTE: *Mandated Screening/Test under CT State Law

*Height:		*Postural:	<input type="checkbox"/> Normal
*Weight:			<input type="checkbox"/> Abnormal
*B/P:		Min. _____	
Pulse:		Slight _____	
*HCT/HGB:		Mod. _____	
Urinalysis:		Marked _____	
*Gross dental:			<input type="checkbox"/> Referral
*Vision/Type of Screening		*Auditory/Type of Screening	
With glasses	R 20/ L 20/	Pass/Fail	R
Without glasses	R 20/ L 20/		L

RECENT IMMUNIZATIONS (Td, Hep. B, etc)	
Immunization	Date

TB and Other Test Results (Sickle Cell, etc.)		
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Test	Date	Results

*Chronic Disease Assessment:		Date of onset
Yes No		
<input type="checkbox"/>	Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	
	<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified	
<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/>	Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex	
<input type="checkbox"/>	Seizure Disorder	
<input type="checkbox"/>	Other: Please specify _____	

	Normal	Abnormal Findings
General Appearance		
Skin		
Heart		
Respiratory		
Cardiovascular		
Arrhythmia		
Murmur		

	Normal	Abnormal Findings
Abdomen		
Spine		
Neurological		
Genitalia (Hernia)		
Extremities		
Physical Maturity (Tanner Stage)		1 2 4 5

Comments: _____

- This student may participate fully in the school program, including physical education activities and competitive sports.
- This student may participate in the school program and physical education with the following restriction/adaptation.
(Specify reason and restriction) _____

Signature of health care provider	Name (please type or print)	Phone Number