Finley School District Pre-participation Sport Evaluation

YOUR HEALTH HISTORY: To Be Completed By Parent/Guardian

Name	❑Male ❑Female	Date of Birth	Your Age (Today)
Address	City / Zip	Phone	
Grade (In the Fall)	School (In the Fall) ❑ FMS ❑ RVHS	Do you have a personal physician? ❑Yes ❑No	
Fall Sport:	Winter / Spring	Physician's Name	

Explain "YES" answers in area following questions below:

		YES	NO
1	Have you ever been hospitalized?		
2	Have you ever had Surgery?		
3	Have you ever had an injury requiring treatment by a physician?		
4	Do you have ongoing medical conditions (Asthma, Diabetes, Infections etc…)		
5	Are you presently taking any medication or pills?		
6	Do you have any allergies (medicine, pollen, food, stinging insects)?		
7	Have you ever passed out during or after exercise?		
8	Have you ever been dizzy during or after exercise?		
9	Have you ever had chest pain, discomfort, tightness or pressure during or after exercise?		
10	Do you tire more quickly that your friends during exercise?		
11	Have you ever had high blood pressure?		
12	Have you been told that you have any heart problems?		
13	Have you ever had racing of your heart or skipped heartbeat?		
14	Has anyone in your family died of heart problems or a sudden death before age 50?		
15	Do you have any skin problems (itching, rashes, acne)?		
16	Have you ever had a head injury or concussion?		
17	Have you ever been knocked out or unconscious?		
18	Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problem?		
19	Have you ever had numbness, tingling, weakness or unable to move your arms or legs after being hit or falling?		
20	Have you ever had a seizure?		
21	Have you ever had a stinger, burner or pinched nerve?		
22	Have you ever had heat or muscle cramps?		
23	Have you ever been dizzy or passed out in the heat?		
24	Do you cough, wheeze or have trouble breathing during or after activity?		
25	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc…)?		
26	Have you had any problems with your eyes or vision?		
27	Do you wear glasses or contacts or protective eye wear?		
28	Have you ever sprained/strained, dislocated, fractured, broke or had repeated swelling or other injuries of any bones or joints?		
29	Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?		
30	Have you had a medical problem or injury since your last evaluation?		
31	Are you worried about your weight?		
32	When was your last tetanus shot?		
33	When was your last measles immunization?		
	FEMALES ONLY		
34	When was your first menstrual period?		
35	When was your last menstrual period?		
36	What was the longest time between your periods last year?		

Explain "YES" answers: (Use a second sheet if necessary)

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete_____ Signature of Parent/Guardian_____Date_____

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To Be Completed By Physician

Height _____ Weight _____ BP _____/_____ Pulse _____ Visual Acuity L 20/___ R 20/___			
	Normal	**Abnormal Findings**	**Initials**
Appearance			
Head			
Eyes/ears/nose/throat			
Lymph nodes			
Chest			
Lungs			
Heart			
Abdomen			
Genitourinary (males Only)			
Neurologic			
Skin			
Physical Maturity			
Neck			
Back & Spine			
Shoulders and Upper Extremities			
Lower Extremities			

Clearance: ❑ Cleared for all sports without restriction

❑ Cleared for all sports with restriction with recommendations for further evaluation or treatment for

_____

❑ Not Cleared

- ❑ Pending further evaluation
- ❑ For any sports
- ❑ For certain sports _____

Reasons and Recommendations:

_____

_____

_____

_____

Name of Physician (Please PRINT) _____ Date _____

Signature of Physician _____