

West Woods Christian Academy

SPORT PARTICIPATION HEALTH RECORD

This evaluation is to determine readiness and give permission for participation in all sports except: _____
 Sport(s) trying out for: _____. This is valid for **one year only**. It should **NOT** be used as a substitute for regular health maintenance examinations. **THIS SIDE MUST BE COMPLETED BY PARENT/GUARDIAN AND STUDENT BEFORE BEING BROUGHT TO THEIR PRIMARY HEALTHCARE PROVIDER.**

NAME: _____ AGE: ____ SEX: ____ SCHOOL: _____

ADDRESS: _____ HOME PHONE: _____ WORK#: _____ GRADE _____

MEDICAL HISTORY (To be completed by student and parent/guardian)

1. Do you have any allergies? (Drug, Food, Insect stings, etc.) NO YES if yes, please list:

2. Are you currently taking any drugs or medications including steroids or protein supplements (Daily occasionally) NO YES
If yes, please list: _____
3. Are you presently being treated for any condition by a physician or other health care professional? NO YES If yes, please list:

4. Have you ever been advised by a health care provider not to participate in any sport? NO YES If yes, please list:

5. Do you have any chronic conditions, disorders or diseases? NO YES If yes, check those applicable:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy (seizures)
<input type="checkbox"/> Hepatitis (liver disease)	<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Other
<input type="checkbox"/> Mononucleosis-Yr _____	<input type="checkbox"/> Kawasaki's Disease	<input type="checkbox"/> Handicap (describe _____)	

Please check where applicable if you have or 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 ½ 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	_____	_____
Loss or gain of more than 10 lbs. in last year	_____	_____	Black or bloody bowel movements (stool)	_____	_____
Special diet for medical reasons	_____	_____	Kidney diseases/problems	_____	_____
Rash or skin problem	_____	_____	Neck, spine, or low back injury or pain	_____	_____
For female participants:			For male participants:		
Absent or irregular monthly periods	_____	_____	Undescended or absent testicles	_____	_____
Disabling cramps with your menstrual periods	_____	_____	Other: (if yes, explain briefly)	_____	_____
Hospitalizations: [] NO [] YES If yes, reasons: _____					

Sprained/strained, dislocated, fractured, broken or repeated swelling or other injuries of any of the following:

Head Neck Shoulder Elbow Forearm Wrist Hand Foot
 Chest Back Hip Thigh Knee Shin/Calf Ankle

Please describe all times checked above: including the year the injury occurred: _____

STUDENT AND PARENT/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. We give permission for release of information on this form for confidential use in meeting any health needs/concerns. We give permission for the school nurse to communicate with the Primary Health Care Provider if necessary.

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

MEDICAL EXAMINATION – To be completed by Medical Doctor or his/her designee

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	NORMAL	ABNORMAL FINDINGS	HEIGHT _____	WEIGHT _____		
APPEARANCE			BLOOD PRESSURE _____	PULSE _____		
SKIN			*HCT/HGB _____	<i>*very important that HCT/HGB &</i>	URINALYSIS <i>are filled in</i>	
HEENT			*URINALYSIS:	PROTEIN _____	BLOOD _____	GLUCOSE _____
RESPIRATORY			VISUAL ACUITY:	_____ RIGHT	_____ LEFT	
CARDIOVASCULAR			CORRECTED TO:	_____ RIGHT	_____ LEFT	
	ARRHYTHMIA		HEARING:			
	MURMUR		BODY FAT(OPTIONAL)	= _____%		
ABDOMEN			CHOLESTEROL (OPTIONAL)	= _____%		
SPINE			LAST TETANUS BOOSTER	DATE: _____		
NEUROLOGICAL			LAST MEASLES (MMR) BOOSTER	DATE: _____		
GENITALIA (hernia)			OTHER IMMUNIZATIONS	DATE: _____		
PHYSICAL MATURITY (TANNER STAGE)	1 2 3 4 5					

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 _____ MEDICATIONS _____
 STRENGTHENING _____ SPECIAL EQUIPMENT _____
 STRETCHING _____ BRACING/TAPING _____
 CONDITIONING (Endurance) _____

I certify that on this date, on the basis of the examination requested by the 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:

 Signature of Medical Doctor or his/her Designee Date of Physical Exam Telephone Medical Doctor (Print or Stamp)