

# SPORTS SCREENING ASSESSMENT

STUDENT'S NAME (PRINT) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ SEX: M F GRADE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ / \_\_\_\_\_ PULSE: \_\_\_\_\_ RESP: \_\_\_\_\_

**CIRCLE APPROPRIATE FINDINGS:**

LUNGS: CLEAR WHEEZING RALES OTHER \_\_\_\_\_ PEAK FLOW \_\_\_\_\_

CARDIAC: RRRsM: MURMURS \_\_\_\_\_ /6: ARRHYTHMIAS OTHER \_\_\_\_\_

ABDOMEN: NORMAL (SOFT, BOWEL SOUNDS NL, NO MASSES) OTHER \_\_\_\_\_

HERNIAS: (INGUINAL, MALES ONLY) FOUND NOT FOUND

NECK: (NORMAL ORM): YES NO (CHIN TO CHEST, 90 DEG ROTATION, EAR TO SHLD R AND L, 45 DEG EXT)

MUSCULOSKELETAL: CHECK ASYMMETRIC ROM, MUSCLE IMBALANCE, JOINT LAXITY, DEFORMITY, PAIN/SWELLING

**CIRCLE ANY JOINT WITH ABNORMAL FINDINGS AND ELABORATE:**

SHOULDER \_\_\_\_\_

ELBOW \_\_\_\_\_

WRIST \_\_\_\_\_

HAND \_\_\_\_\_

BACK \_\_\_\_\_

HIPS \_\_\_\_\_

KNEES \_\_\_\_\_

ANKLES \_\_\_\_\_

FEET \_\_\_\_\_

**EVALUATION (CIRCLE ONE)**

1. UNLIMITED ATHLETIC PARTICIPATION

2. MAY PARTICIPATE PENDING FURTHER EVALUATION

Recommendation for further W/U \_\_\_\_\_

Referral to: \_\_\_\_\_

3. LIMITED ATHLETIC PARTICIPATION

Orthopedic limitations \_\_\_\_\_

4. ATHLETIC PARTICIPATION DENIED

Reasons \_\_\_\_\_

SIGNATURE OF EXAMINING/EVALUATING PHYSICIAN \_\_\_\_\_

DATE: (Mandatory) \_\_\_\_\_

## SPORTS SCREENING HEALTH QUESTIONNAIRE

STUDENT'S NAME \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

DATE OF LAST VISIT/PHYSICAL \_\_\_\_\_

**MEDICAL HISTORY:** It is important this form be filled out completely and accurately by a parent or legal guardian. It is an important part of providing health care to your child, and allows the physicians focus on important areas specific to your child. Please circle all appropriate answers.

**ALLERGIES?** Y/N    **DRUGS:** Penicillin    Sulfa    Other \_\_\_\_\_

**ENVIRONMENTAL:** Bee stings    Pollen    Dust    Other \_\_\_\_\_

What happens during the allergic reaction? \_\_\_\_\_

Current Prescription medications? \_\_\_\_\_

Reason for medication \_\_\_\_\_

Bone, joint, tendon or ligament injuries requiring medical attention? Y/N

Explanation \_\_\_\_\_

Neck or back injuries/problems? Y/N

Explanation \_\_\_\_\_

Any previous surgery? Y/N

Explanation \_\_\_\_\_

Any previous hospitalizations? Y/N

Explanation \_\_\_\_\_

Any history of loss of consciousness? Y/N

If "Yes", was the athlete:    knocked out    fainted?

Any history of seizures? Y/N

Explanation \_\_\_\_\_

Wear glasses    contacts? Y/N

Any history of asthma? Y/N    If "Yes" is an inhaler required? Y/N

Has your child ever had any PE class limitations? Y/N

Explanation \_\_\_\_\_

Are immunizations current? Y/N

Any uncorrected visual condition that may impair sports participation? Y/N

Any significant medical problems such as: **(Circle all appropriate answers)**

- Loss of an organ (i.e. kidney, spleen, eye, etc)
- Bleeding problems (Anemia Sickle cell, hemophilia, etc)
- Respiratory problems (i.e. Shortness of breath, asthma, tuberculosis, collapsed lungs, etc.)
- Cardiac problems (i.e. Murmur, etc.)
- Psychiatric problems requiring medical treatment
- Leukemia
- Menstrual problems

Any family history of: **(Circle all appropriate answers)**

Diabetes requiring insulin    Bleeding problems    Heart problems    other \_\_\_\_\_

Is there any other medical condition that you know of that should be brought to the attention of the physicians or any reason why the athlete should be limited or withheld from athletic participation? **Y/N**

Explanation \_\_\_\_\_

**I hereby certify that the above information is true and correct.**

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_