St. Vrain Valley Schools Student Medical History and Physical Exam

The medical history information is helpful to physical screening athletes so they may participate in District athletic programs safely, and it expedites the physical process. *You and your* student are REQUIRED to complete the form *together* and it must be presented at the Exam. The form, and any further clearance items specified by the form, must be on file with the school administration before your student is allowed to participate in athletics. If any problems arise between the time of this physical exam and the beginning of your sport, bring them to the attention of your physician.

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
Have you had a medical illness or injury since your last check up or sports physical?	___	___
Do you have an on going or chronic illness?	___	___
Have you ever been hospitalized overnight?	___	___
Have you ever had surgery?	___	___
Are you currently taking any prescription or Non-prescription (over-the-counter) medication or pills or using an inhaler?	___	___
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___
Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	___	___
Have you ever had a rash or hives develop during or after exercise?	___	___
Have you ever passed out during or after exercise?	___	___
Have you ever been dizzy during or after exercise?	___	___
Have you ever had chest pain during or after exercise?	___	___
Do you get tired more quickly than your friends during exercise?	___	___
Have you ever had racing of your heart or skipped heartbeats?	___	___
Have you had high blood pressure or high cholesterol?	___	___
Have you been told you have a heart murmur?	___	___
Has any family member or relative died of heart problems or of sudden death before age 50?	___	___
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters?	___	___
Have you ever had a head injury or concussion?	___	___
Have you ever been knocked out, become unconscious, or lost your memory?	___	___
Have you ever had a seizure?	___	___
Do you have frequent or severe headaches?	___	___
Have you ever had numbness or tingling in your arms, legs, or feet?	___	___
Have you ever had a slinger, burner, or pinched nerve?	___	___
Have you ever become ill from exercising in the heat?	___	___
Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
Do you have asthma?	___	___
Do you have seasonal allergies that require medical treatment?	___	___

	Yes	No
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
Have you had any problems with your eyes or vision?	___	___
Do you wear glasses, contacts or protective eyewear?	___	___
Have you ever had a sprain, strain, or swelling after injury?	___	___
Have you broken or fractured any bones or dislocated any joints?	___	___
Have you ever had any other problems or swelling, in muscles, tendons, bones, or joints?	___	___

If Yes, check appropriate line and explain below:

___Hand	___Elbow	___Hip
___Neck	___Forearm	___Thigh
___Back	___Wrist	___Knee
___Chest	___Hand	___Shin/Calf
___Shoulder	___Finger	___Ankle
___Upper arm		___Foot

Explain "Yes" answers here:

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

Athlete signature _____ Parent signature _____ Date _____

Name _____ Age _____ Date _____

Grade _____ School _____ Sport (s) _____

Address _____ Phone _____

In case of emergency, contact:

Name _____

Relationship _____ Phone (H) _____ (W) _____

Personal Physician

_____

Blood Pressure #1 _____ #2 _____ Ht _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			

Medical Clearance:
___ Cleared
___ NOT cleared. Need further evaluation of _____

Physician Signature: _____ Date _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

Orthopedic Clearance:
___ Cleared
___ NOT cleared. Need further evaluation of _____

Physician Signature: _____ Date _____

Further Evaluation/Clearance:
I have reviewed this pre-participation evaluation form, and I have examined this athlete for the medical problem he or she was not cleared for. After further evaluation, the athlete is:
____ Cleared ____ Not Cleared
Notes for further
Recommendations: _____

_____

Final Physician Name: _____ Date _____

Final Clearance Physician Signature: _____