

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	Yes	No
Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	
Do you have an on going or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any problems with your eyes or vision?	
Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts or protective eyewear?	
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a sprain, strain, or swelling after injury?	
Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any other problems or swelling, in muscles, tendons, bones, or joints?	
Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If Yes, check appropriate line and explain below:</i>	
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/> Elbow
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand
Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Hip
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thigh	<input type="checkbox"/> Knee
Have you been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Ankle
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here:	
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had numbness or tingling in your arms, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a slinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>		

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 _____

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

Medical Clearance:

Cleared
 NOT cleared. Need further evaluation of _____

Physician Signature: _____ Date _____

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
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: _____