

Students Name (Print) _____

UNIVERSITY PREPARATORY SCHOOL
Athletics Health Screening Examination Record

Date of Birth _____

Telephone # _____

Age: _____ Gender: _____ Height: _____ Weight: _____

Health Screening Examination
(To be completed and signed by a physician)

Pulse Rate: _____ Blood Pressure: _____

Health History
(To be completed and signed by parent/guardian)

Has your child ever had or does he/she now have any of the following?

Yes No (Please explain any yes answers)

1. Chronic or recurrent illnesses _____
2. Illnesses lasting more than a week _____
3. Hospitalizations _____
4. Surgery, other than tonsillectomy _____
5. Problem with blood pressure or heart _____
6. Dizziness, fainting or frequent headaches _____
7. Ever been knocked out or had a concussion or lost memory _____
8. Neck/back injury or surgery, numbness or tingling in arms, hands, legs or feet _____
9. A stinger, burner or pinched nerve? _____
10. Knee, ankle injury or surgery _____
11. Other joint sprains or dislocation, pain or swelling _____
12. Broken bones (fractures) _____
13. Epilepsy or seizure disorder _____
14. Asthma or shortness of breath _____
15. Diabetes _____
16. Illness from exercising in the heat _____
17. Nervous disorder or mental illness _____
18. Currently taking any medications _____
19. Allergic to any medications (aspirin, penicillin, etc.) or bee stings _____
20. Wear eyeglasses or contact lenses _____
21. Wear dental appliances, orthotics or prosthetic equipment _____
22. Desire to weigh more or less than current weight. Lose weight regularly to meet weight requirements for sports _____
23. Stressed out feeling _____

Please use this space to further explain the above answers or for additional information:

Parent/Guardian Permission and Release

I declare that the above information is correct to the best of my knowledge. I understand this is a screening examination to determine if any obvious medical problems exist to prevent my child from participating in school athletic events. This examination is not a complete medical examination. You should contact your family physician for your medical needs. If any medical problems are identified in this screening examination, further examination and treatment should be obtained through your physician.

Parent/Guardian Signature

Date

	Normal	Abnormal	Comments
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Lungs			
Abdomen			
Genitalia/Hernia (males only)			
Skin			
Neck/Spine			
Arms/Shoulders/Elbows			
Wrists/Hands			
Legs/Hips/Thighs/Knees			
Ankles/Feet			

Based on this history and physical exam the following **ABNORMALITIES** were found and need further evaluation before clearance for competitive athletics:

1. _____
2. _____
3. _____

Recommendations:

- CLEARED** - There were no history or physical findings on this exam which would prohibit this student from participating in competitive athletics.
- This student should have the above **health problems evaluated or treated PRIOR** to participating in competitive athletics.
- This student has health problems which would **PROHIBIT** him or her from participating in competitive athletics.

Physician Name (print/type)

Phone

Physician Signature

Date