# DARIEN PUBLIC SCHOOLS
# SPORTS PARTICIPATION HEALTH RECORD

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. THIS SIDE MUST BE COMPLETED BY PARENT AND STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.

Name _______________________________________________ Sex _____ Age ______ Date of Birth ____________Grade ______

Address ______________________________________________Tel __________________ Personal Physician _________________

Fall Sport __________________________ Winter Sport _________________________ Spring Sport _________________________

**MEDICAL HISTORY**
(to be completed by parent or guardian)

1. Do you have any allergies? (food, drugs, insect stings, etc.)
   YES ____ NO ____ List: ___________________________________________________________________________
2. Are you currently taking any drugs or medications including steroids or protein supplements? (daily or occasionally)
   YES ____ NO ____ List: ___________________________________________________________________________
3. Are you presently being treated for any condition by a physician or other health care professional?
   YES ____ NO ____ Explain: ________________________________________________________________________
4. Have you ever been advised by a doctor not to participate in any sport?
   YES ____ NO ____ Explain: _________________________________________________________________________
5. Do you have any chronic conditions, disorders or diseases?
   YES ____ NO ____ if yes, check those applicable:

| | | |
|---|---|---|
| Asthma ____ | Bleeding Disorders ____ | Diabetes ____ |
| Epilepsy (seizures) ____ | Hepatitis (liver disease) ____ | Sickle Cell Anemia ____ |
| Hypertension (high blood pressure)____ | Mononucleosis ____ year ______ | Kawasaki's Disease ____ |

Disability (describe) _______________________________________Other _________________________________

Please check where applicable if you have or have had any of the following:

| YES | NO | |
|---|---|---|
| ____ | ____ | Head injury, concussion, or been unconscious<br>If yes, how many times _________ |
| ____ | ____ | Headaches more than once a week |
| ____ | ____ | Lack of feeling or numbness in any part of the body |
| ____ | ____ | Heat exhaustion or heat stroke |
| ____ | ____ | Difficulty running ½ mile without stopping |
| ____ | ____ | Chest pain, dizziness or passing out during exercise |
| ____ | ____ | Coughing, wheezing or gasping for breath with exercise or cold weather |
| ____ | ____ | Smoke cigarettes or chew tobacco |
| ____ | ____ | Heart problem, murmur or arrhythmia |
| ____ | ____ | Family member with a heart attack under age 50 |
| ____ | ____ | Loss or gain of more than 10 lbs. in last year |
| ____ | ____ | Special diet for medical reasons |
| ____ | ____ | Eye injury or retinal detachment |
| ____ | ____ | Blurred vision or vision in one eye only |
| ____ | ____ | Wear glasses or contact lenses |

| | YES | NO |
|---|---|---|
| Hearing loss or impairment in one or both ears | ____ | ____ |
| Tubes in ears or a perforated eardrum | ____ | ____ |
| False teeth, caps or braces | ____ | ____ |
| Nose bleeds for no reason | ____ | ____ |
| Bruising easily or taking a long time to stop bleeding when cut | ____ | ____ |
| Diarrhea more than once a week | ____ | ____ |
| Black or bloody bowel movements (stools) | ____ | ____ |
| Kidney disease or dark, brown or bloody urine | ____ | ____ |
| Less than 2 kidneys or, in males, 2 testicles | ____ | ____ |
| Lump(s) in armpit or groin | ____ | ____ |
| Rash or skin problem | ____ | ____ |
| Neck or spine or low back injury or pain | ____ | ____ |
| **For female participants:** | | |
| Disabling cramps with your menstrual periods | ____ | ____ |
| Absent or irregular monthly periods | ____ | ____ |

____ ____ Hospitalized for medical or surgical reasons? If yes, please provide the following information:

| Reason | Year | Hospital |
|---|---|---|
| ____________________________________________________ | ___________ | _____________________________________ |

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more?

| Injury Area<br>(Knee, Hamstring, Neck, Shin, etc.) | Year | Side<br>(Right, Left) | Type<br>(Fracture, Sprain, Swelling, Pinched Nerve, etc.) | Resolved<br>Yes | <br>No |
|---|---|---|---|---|---|
| __________________________ | ______ | _______ | ___________________________________________ | ____ | ____ |
| __________________________ | ______ | _______ | ___________________________________________ | ____ | ____ |
| __________________________ | ______ | _______ | ___________________________________________ | ____ | ____ |
| __________________________ | ______ | _______ | ___________________________________________ | ____ | ____ |

**STUDENT AND PARENT OR 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.

________________________________________ ______________________ ___________________________________

Student Signature Date Parent or Guardian Signature

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MEDICAL EXAMINATION
(to be completed by Medical Doctor or his/her designee)

___________________________________ ____/____/____ has had a complete history and physical exam on ____/____/____
Student's Name Date of Birth

| | Normal | Abnormal Findings |
|---|---|---|
| Appearance | | |
| Skin | | |
| HEENT | | |
| Respiratory | | |
| Cardiovascular | | |
| | Arrhythmia__________________<br>Murmur | |
| Abdomen | | |
| Spine | | |
| Neurological | | |
| Genitalia (hernia) | | |
| Physical Maturity (Tanner Stage) 1 2 3 4 5 | | |

HEIGHT ______'__ __" WEIGHT ____________
BLOOD PRESSURE ________________ PULSE____________
HCT/HGB ________________________
URINALYSIS __________ protein _____ blood _____ glucose _____
VISUAL ACUITY: right ______________ left ______________
Corrected to right ______________ left ______________
HEARING ____________________________________________
GROSS DENTAL ____________________________________________
BODY FAT (optional) __________________________
CHOLESTEROL (optional) __________________________

LAST TETANUS BOOSTER Date ___________________
LAST MEASLES (MMR) BOOSTER Date __________________
Date HBV 1__________ HBV 2__________ HBV3 ____________
Varicella: Disease Date _________or Immunization Date________
OTHER IMMUNIZATIONS ___________________Date _________

CHRONIC DISEASE ASSESSMENT

Asthma: __mild __moderate __severe __exercise induced
Diabetes: _____ Type I _____ Type II
TB: IN HIGH RISK GROUP ___YES ___ NO
TB Test ____________ Date _________ Results _________
Seizure Disorder: ___________________
Anaphylactic Reaction: ____ food ____ insect ____ latex
Other: Please specify ________________________________

SUMMARY: ______________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

ORTHOPEDIC EXAM
MUSCULO-SKELETAL 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 ___________________________
Strengthening ___________________________
Stretching ___________________________
Conditioning (Endurance) ___________________________
Medications ____________________________
Special Equipment ___________________________
Bracing / Taping ____________________________

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: ________________________________________________________________________________
______________________________________________________________________________________________

_______________________________, M.D. _______________ ____________________ _____________________________
Signature of Medical Doctor or designee Date Telephone Medical Doctor (Print or Stamp)

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