Sport Physical Evaluation

Juneau School District **Health History**

Name _____ Sex _____ Age _____

Date of Birth _____ Grade _____

School _____ Sport(s) _____

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	○	○
2. Do you have an ongoing medical condition (like diabetes or asthma)?	○	○
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? _____	○	○
4. Do you have allergies to medicines, pollens, foods, or stinging insects? _____	○	○
5. Have you ever passed out or nearly passed out with exercise?	○	○
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	○	○
7. Does your heart race or skip beats during exercise?	○	○
8. Has a doctor ever told you that you have (check all that apply): ○ High blood pressure ○ A heart murmur ○ High cholesterol ○ A heart infection		
9. Does anyone in your family have a heart problem?	○	○
10. Has any family member or relative died of heart problems or of sudden death before age 50?	○	○
11. Have you ever spent the night in a hospital? _____	○	○
12. Have you ever had surgery? _____	○	○
13. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:		
14. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

	Yes	No
15. Do you regularly use a brace or assistive device?	○	○
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	○	○
17. Is there anyone in your family who has asthma?	○	○
18. Have you ever used an inhaler or asthma medicine?	○	○
19. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	○	○
20. Have you had infectious mononucleosis (mono) within the last month?	○	○
21. Do you have any rashes, pressure sores, or other skin problems?	○	○
22. When exercising in the heat, do you have severe muscle cramps or become ill?	○	○
23. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	○	○
24. Have you had any problems with your eyes or vision?	○	○
25. Are you trying to gain or lose weight?	○	○
26. Has anyone recommended you change your weight or eating habits?	○	○
27. Do you have any concerns that you would like to discuss with a doctor?	○	○
FEMALES ONLY		
28. Have you ever had a menstrual period?	○	○
29. How old were you when you had your first menstrual period? ___		
30. Do you have monthly periods?	○	○

Explain "Yes" answers here:

_____

_____

_____

_____

_____

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

Signature of Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____

This form was filled out by: ○ **self** ○ **parent/guardian**

Sport Physical Evaluation

Juneau School District **Examination Form**

To be completed by physician, physician assistant, or advance nurse practitioner

Name_____ Date of Exam _____

Height_____ Weight_____ Pulse_____ BP_____ / _____

Vision R 20/_____ L 20/_____ Corrected: Y N Glasses/ Contacts

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Lymph nodes			
Heart			
Lungs			
GI			
Genitourinary (males)			
Skin			
Neuro			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

- ❑ Cleared
- ❑ Cleared after completed evaluation/rehabilitation for _____
- ❑ Not cleared: Explain: _____

_____

_____

Name of MD PA ANP (circle which) (print/type)_____

Phone: _____

Signature of provider_____ Date_____