Hanover High School Sports Qualifying Screening Evaluation

H-1463

Student Name: ______________________

Address: ______________________

Telephone: ____________ Age: ________

Date of Birth: ____________ Male ( ) Female ( )

Grade: ______ School: ______________________

Personal Physician: ______________________

Address: ______________________

____

Telephone: ______________________

PLEASE COMPLETE PRIOR TO EXAMINATION

HISTORY

		YES	NO
1.	Have you ever fainted?	( )	( )
	During exercise?	( )	( )
	Have you every had chest pain during exercise?	( )	( )
2.	Family history of sudden death?	( )	( )
	Before age 35? _______ Before age 50? _______		
	Cause ______________________		
3.	Have you ever had a concussion, loss of consciousness, or head injury?	( )	( )
	If yes, how many? _________		
4.	Have you ever had heat stroke or heat exhaustion?	( )	( )
5.	Do you wheeze or cough during or after exercise?	( )	( )
	Do you have any history of asthma?	( )	( )
6.	Do you have any allergies? (medications, bee sting, pollens, etc.) ______________	( )	( )
7.	Any sports-related injuries since last exam?	( )	( )
	If yes, list injuries: ______________		
8.	Have you been ill in the last month?	( )	( )
9.	Do you take any medication? (include vitamins and nonprescription drugs) ______________	( )	( )
10.	Have you ever been hospitalized?	( )	( )
	Have you ever had surgery?	( )	( )
	If yes, explain? ______________		

11. If female, last menstrual period: ______________
Age at onset of first period: ______________

12. In the last year, what was your:
Lowest weight ________ Highest weight ________
What do you think is your ideal weight? ________

13. Immunizations: Last tetanus ________
Last Measles, Mumps, German Measles (MMR) ________

14. Circle any of the following you have had:

Abnormal bleeding/bruising	Anemia
Broken bones/stress fracture	Diabetes
Dislocation (shoulder, etc.)	Hearing Impairment
Heart murmur/palpitations	Hepatitis/jaundice
High blood pressure	Loss of eye sight
Rheumatic fever	Scoliosis
Seizures	Sickle-cell disease
Single organs (kidney, eye, etc.)	Undescended testicle

Other ______________________

		YES	NO
15.	Do you use seat belts on a regular basis?	( )	( )
16.	Are there any concerns you would like to discuss?	( )	( )

EXAMINATION

			YES	NO
HT ______ WT ______ BP ____/____		Glasses	( )	( )
Vision	R ______ L ______	Contact Lenses	( )	( )
Anisocoria	R ______ L ______	Eye Protection	( )	( )

MEDICAL EXAM

	Normal	Abnormal	Comments
HEENT			
Funduscopic Exam	____	____	________
Ears	____	____	________
Mouth	____	____	________
Throat	____	____	________
Dental	____	____	________
Thyroid	____	____	________
Nodes	____	____	________
Lungs	____	____	________
Heart/Murmurs	____	____	________
Abdomen	____	____	________
Genitalia	____	____	________
Hernia	____	____	________
Skin	____	____	________
Body Fat % (opt)	____	____	________

MATURATION INDEX (approx. maturation age) optional
Girls 12-1/2 + (chronological age - age at menarche) = ________
Boys (estimate): 11 + Tanner Stage = ________
Labs if indicated ______________________

MUSCULOSKELETAL

	Normal	Abnormal		Normal	Abnormal
Neck	____	____	Quad/Hamstring	____	____
Shoulder	____	____	Ankle/Feet	____	____
Elbow	____	____	Back/Spine	____	____
Hands	____	____	Toe/Heel Walk	____	____
Wrist	____	____	Duck Walk	____	____
Knees	____	____			

Comments ______________________

I herewith certify that ______________________ has been
(student)
evaluated in the following areas as indicated below to be physically fit to participate in school interscholastic activities.

Medical History	Y/N	____________ (name)
Medical Exam	Normal/Abnormal	____________ (name)
Musculoskeletal	Normal/Abnormal	____________ (name)

	Cleared For	Not Cleared For
Collision Sports	( )	( )
Contact Sports	( )	( )
Noncontact Sports	( )	( )

Due to: ______________________
Modifications or exceptions: ______________________

Attending Physician Signature ______________________
Print name ______________________ Date __________
Athlete's Signature ______________________ Date __________

I do not know of any existing physical condition or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I appropriate participation in athletic activities.

I hereby authorize release to the school nurse of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Parent's Signature ______________________ Date ______________
(Parent or Legal Guardian)