

**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?	___	___	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?	___	___	Have you had any problems with your eyes or vision?	___	___
Have you ever been hospitalized overnight?	___	___	Do you wear glasses, contacts or protective eyewear?	___	___
Have you ever had surgery?	___	___	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?	___	___	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?	___	___	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)?	___	___	<i>If Yes, check appropriate line and explain below:</i>		
Have you ever had a rash or hives develop during or after exercise?	___	___	___ Hand	___ Elbow	___ Hip
Have you ever passed out during or after exercise?	___	___	___ Neck	___ Forearm	___ Thigh
Have you ever been dizzy during or after exercise?	___	___	___ Back	___ Wrist	___ Knee
Have you ever had chest pain during or after exercise?	___	___	___ Chest	___ Hand	___ Shin/Calf
Do you get tired more quickly than your friends during exercise?	___	___	___ Shoulder	___ Finger	___ Ankle
Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Upper arm	___	___ Foot
Have you had high blood pressure or high cholesterol?	___	___	Explain "Yes" answers here:		
Have you been told you have a heart murmur?	___	___	_____	_____	_____
Has any family member or relative died of heart problems or of sudden death before age 50?	___	___	_____	_____	_____
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	_____	_____	_____
Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	_____	_____	_____
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___	_____	_____	_____
Have you ever had a head injury or concussion?	___	___	_____	_____	_____
Have you ever been knocked out, become unconscious, or lost your memory?	___	___	_____	_____	_____
Have you ever had a seizure?	___	___	_____	_____	_____
Do you have frequent or severe headaches?	___	___	_____	_____	_____
Have you ever had numbness or tingling in your arms, legs, or feet?	___	___	_____	_____	_____
Have you ever had a slinger, burner, or pinched nerve?	___	___	_____	_____	_____
Have you ever become ill from exercising in the heat?	___	___	_____	_____	_____
Do you cough, wheeze, or have trouble breathing during or after activity?	___	___	_____	_____	_____
Do you have asthma?	___	___	_____	_____	_____
Do you have seasonal allergies that require medical treatment?	___	___	_____	_____	_____

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 \_\_\_\_\_

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

Medical Clearance:

\_\_\_ Cleared

\_\_\_ NOT cleared. Need further evaluation of \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
MUSCULOSKELETAL			
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:** \_\_\_\_\_