

Northwestern Regional School District 7 Connecticut Pre-participation Sports Evaluation

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ % Body Fat: _____ Pulse: _____ BP ____/____ (____/____, ____/____)

Vision: R= ____/____ L= ____/____ Corrected: Y N Pupils: Equal _____ Unequal _____

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Please record the most recent immunizations: _____

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- _____
- _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (Print) _____ Phone: _____

Address: _____

Signature of Physician: _____

Date of Exam: _____

Sports physicals are good for 1 (one) year from date of exam.

Connecticut Interscholastic Athletic Conference 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 & STUDENT BEFORE BEING BROUGHT TO THE DOCTORS OFFICE.

Name: _____ Age: _____ Grade: _____ Gender: _____

Address: _____ Phone: _____

Sports Being Played (1) _____ (2) _____ (3) _____

MEDICAL HISTORY—to be completed by student and parent or guardian

1. Do you have any allergies? (Drugs, Food, Insect Stings, etc.)
 _____ **YES**; list: _____ **NO**
 2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally).
 _____ **YES**; list: _____ **NO**
 3. Are you presently being treated for any condition by a physician or other health care professional?
 _____ **YES**; explain: _____ **NO**
 4. Have you ever been advised by a doctor not to participate in any sport?
 _____ **YES**; explain: _____ **NO**
 5. Do you have any chronic conditions, disorders or diseases? Check those applicable or _____ **NO**
- _____ Asthma _____ Hypertension (High Blood Pressure) _____ Handicap (Describe) _____
 _____ Hepatitis (liver disease) _____ Diabetes _____
 _____ Mononucleosis-YR _____ _____ Epilepsy (Seizures) _____ Other chronic illness (list) _____
 _____ Bleeding Disorders _____ Anemia _____

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

	Yes	No		Yes	No
Head Injury, concussion, or been unconscious	_____	_____	Hearing loss or impairment in one or both ears	_____	_____
If yes, how many times _____			Tubes in ears or a perforated eardrum	_____	_____
Headaches more than once a week	_____	_____	False teeth, caps or braces	_____	_____
Lack of feeling or numbness in any part of the body	_____	_____	Nose bleeds for no reason	_____	_____
Heat exhaustion or heat stroke			Bruising easily or taking a long time to stop		
Difficulty running 1/2 mile without stopping	_____	_____	bleeding when cut	_____	_____
Chest pain, dizziness or passing out during exercise	_____	_____	Diarrhea more than once a week	_____	_____
Coughing, wheezing or gasping for breath	_____	_____	Black or bloody bowel movements (stools)	_____	_____
with exercise or cold weather			Kidney disease or dark or bloody urine	_____	_____
Smoke cigarettes or chew tobacco	_____	_____	Less than two kidneys	_____	_____
Heart problem, murmur or arrhythmia	_____	_____	Lump(s) in arm pit or groin	_____	_____
Family member with a heart attack under age 50	_____	_____	Rash or skin problem	_____	_____
Loss or gain of more than 10 lbs. in last year	_____	_____	Neck, spine or low back injury or pain	_____	_____
Special diet for medical reasons	_____	_____	Please explain any Yes answers: _____		
Eye injury or retinal detachment	_____	_____	_____		
Blurred vision or vision in one eye only	_____	_____	_____		
Wear glasses or contact lenses	_____	_____			

Have you ever been hospitalized for medical or surgical reasons? **YES** _____ **NO** _____

If yes, provide the following information:

<u>REASON</u>	<u>YEAR</u>	<u>HOSPITAL</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any of the following bones, joints or muscles?

- | | | | | | | |
|--------------------------------|-------------------------------|-----------------------------------|--------------------------------|----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Elbow | <input type="checkbox"/> Forearm | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Back | <input type="checkbox"/> Hip | <input type="checkbox"/> Thigh | <input type="checkbox"/> Knee | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Ankle <input type="checkbox"/> Foot |

Please describe all items check above, including the year injury occurred: _____

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 _____ DATE _____

***students who carry an inhaler or epipen must have them with them at all practices and games or they cannot participate.**