EAST GRANBY PUBLIC SCHOOLS

Part I **SPORTS PARTICIPATION HEALTH RECORD AND CONSENT**

To be completed by athlete and/or parent prior to doctor's visit. **All sections must be completed. Sports physicals and consents are valid for one year from the date of the physical and consent.** This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Name: ______________________ Age/Yrs.: ______ Grade: __________ Date of Birth: ______________

Address: ______________________________ Phone: ______________________

Sports over next 12 months: ______________________________

Part A – Health History

	Yes	No
1. Have you ever had an illness that:		
a. required you to stay in the hospital?	☐	☐
b. lasted longer than a week?	☐	☐
c. caused you to miss 3 days or more of practice or competition?	☐	☐
d. is chronic? (i.e., asthma, diabetes, seizure disorder, etc.	☐	☐
e. required an operation?	☐	☐

If yes, please indicate:
a. Reason for hospitalization ______________________
b. Type of surgery ______________________

	Yes	No
2. Have you ever had an injury that:		
a. required you to go to an emergency room or see a doctor?	☐	☐
b. required you to stay in the hospital?	☐	☐
c. required x-rays?	☐	☐
d. caused you to miss 3 days or more of school, practice or competition?	☐	☐
e. required an operation?	☐	☐

If yes, please indicate:
a. Type of injury ______________________
b. Type of surgery ______________________

	Yes	No
3. Have any members of your family, under age 50 had a heart attack, heart problem, or died unexpectedly?	☐	☐
4. Have you ever been?		
a. dizzy or passed out during or after exercise?	☐	☐
b. unconscious or had a concussion?	☐	☐
5. Are you able to run ½ mile (2 times around a track) without stopping?	☐	☐
6. Do you:		
a. wear glasses or contacts?	☐	☐
b. Wear dental bridges, plates or braces?	☐	☐
7. Have you ever had a heart murmur, high blood pressure, or a heart abnormality?	☐	☐
8. Do you have any allergies to any medicine, foods or bee stings.	☐	☐
9. Are you missing a kidney?	☐	☐

10. List all medications you are presently taking and what condition the medication is for.
a. ______________________
b. ______________________
c. ______________________

For Women

a. At what age did you experience your first menstrual period? ______________________
b. In the last year what is the longest time you have gone between periods? ______________________

Explain all "YES" Answers:

____
____
____
____

Part II

AUTHORIZATION FOR HEALTH CARE SERVICES: I/we hereby designate the health services personnel, the team coach, or his/her designee to act on my/our behalf to authorize such hospitalization, medical attention, surgery and any other health care services as may be recommended in an emergency because of illness or injuries sustained by this student while preparing for or participating in interscholastic athletics. I/we hereby assume all financial responsibility for all health care services so provided. I/we request that we be contacted within a reasonable time in the event of illness or injuries to this student requiring health care services.

Work Phone Mother: ______________________ Work Phone Father: ______________________

Emergency Contact: ______________________ Phone: ______________________

Hospital Preference: ______________________ Insurance: ______________________

Physician: ______________________ Phone: ______________________

Dentist: ______________________ Phone: ______________________

______________________ ______________________
Signature of Parent/Guardian **Date**

MEDICAL EXAMINATION – TO BE COMPLETED BY MEDICAL DOCTOR OR HIS/HER DESIGNEE

Name: ______________________ Date of Birth: ____________

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE (Scoliosis)		
NEUROLOGICAL		
GENITALIA (Hernia)		
PHYSICAL MATURITY	(Tanner Stage) 1 2 3 4 5	

HEIGHT: ____________ WEIGHT: ________

BLOOD PRESSURE: _______ PULSE: ________

HGT/HGB: ______________________

URINALYSIS: ____ Protein _____ Blood ____ Glucose

VISUAL ACUITY: ______ Right _____ Left
CORRECTED TO: ______ Right _____ Left

HEARING: ______________________

BODY FAT (optional) = ________________ %

CHOLESTEROL (option) = ________________ %

LAST TETANUS BOOSTER: Date: _____

LAST MEASLES (MUMPS) BOOSTER: Date: _____

ORTHOPEDIC EXAM

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY:

	Normal	Abnormal Findings
NECK		
SPINE		
SHOULDERS		
ARMS/HANDS		
THIGHS		
KNEES		
ANKLES		
FEET		

RECOMMENDATIONS

WEIGHT LOSS/GAIN: ______________________

STRENGTHENING: ______________________

STRETCHING: ______________________

CONDITIONING: ______________________

MEDICATIONS: ______________________

SPECIAL EQUIPMENT: ______________________

BRACING/PACING: ______________________

I certify that on this date I have examined this student and reviewed his/her history and that, 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 complete in supervised athletic activities except those listed below.

____

____

____

Signature of Medical Doctor ____________ Date of Exam ____________ Telephone ____________ Medical Doctor (Print) ____________

This form was developed and approved by Connecticut Chapter, Committee on School Health – American Academy of Pediatrics Connecticut Chapter, Committee on Sports Medicine – American Academy of Pediatrics – The Connecticut State Medical Society Committee on the Medical Aspects of Sports.