Platte Valley School District RE-7 – Sport Physical

Medical History and Physical Evaluation

Student Name__________ Date of Birth__/__/__ Age _____ Grade _____ Sex _____

Parent/Guardian Name __________ Address __________ Phone __________

School Name__________ Current Daily Medications __________

PARENT/GUARDIAN: Please complete and sign this side of form prior to physical exam

1. Has there been a major medical illness or injury since your last physical exam? .... Y N
2. Is there a history of birth injury, abnormal growth and development, or history of congenital defects with the student or family? .... Y N
3. Have you ever been hospitalized overnight or had surgery of any kind? .... Y N
4. Is there a history of chronic illness such as: asthma, diabetes, epilepsy, heart condition, allergies, kidney disease, or other? .... Y N
   Do you currently take any prescription, non-prescription (over-the counter) medications, inhalers, or use an epi pen? .... Y N
5. Have you ever had any hearing or speech problems? .... Y N
6. Have you ever become dizzy or passed out during or after exercise? .... Y N
   Have you ever had chest pain during or after exercise? .... Y N
   Have you ever had racing of your heart or skipped heart beats? .... Y N
   Have you ever been told you have a heart murmur? .... Y N
   Has a family member or relative died of heart problems or of sudden death before age 50? .... Y N
   Has a physician ever denied or restricted your participation in sports because of a heart problem? .... Y N
7. Have you ever had a problem or injury to your eyes or vision, requiring glasses, contacts, an artificial eye, or protective eyewear? .... Y N
8. Have you ever had a head injury or concussion? .... Y N
   Have you ever had a facial injury (broken nose, facial bones, teeth) or have prosthetic dental devices, or braces .... Y N
   Have you ever been knocked out, become unconscious, or lost your memory? .... Y N
   Do you have frequent or severe headaches? .... Y N
   Have you ever had a seizure? .... Y N
9. Have you ever become ill from exercising in the heat? .... Y N
10. Do you have any current skin problems such as: rash, itching, acne, warts, fungus, or blisters? .... Y N
11. Do you use any special protective or corrective equipment (knee brace, neck roll, foot orthotics, prosthetics, hearing aids)? .... Y N
12. Have you ever had a sprain, strain or swelling after exercise? .... Y N
    Have you ever broken (fractured) any bones or dislocated any joints? .... Y N
13. Do you want to weigh more or less than you do now? .... Y N
    Do you lose or gain weight regularly to meet weight requirements for your sport? .... Y N
    Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance? .... Y N

FEMALES ONLY

14. When was your first menstrual period? (date) __________
    When was your most recent menstrual period? (date) __________
    How many days do you usually have from the start of one period to the start of your next period? __________ days.
    Do you have painful periods requiring medications? (explain) __________

Explain all "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 _____

PARENT/GUARDIAN Permit for Student Participation

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk.

Participants have the responsibility to help reduce the chance of injury. PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR OWN EQUIPMENT DAILY.

By signing the Permission Form, we acknowledge that we have read and understood this warning. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THIS RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.

I hereby give my consent for __________ to compete in athletics for PLATTE VALLEY SCHOOLS, in Northern Plains Middle Level Association-Approved Sports (MS) or Colorado High School Activities Association-Approved Sports (HS), except those crossed out: Baseball, Basketball, Cross Country, Cheerleading/Poms, Football, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track and Field, Wrestling, Volleyball

I understand my child cannot participate in athletics unless he/she is covered by the school accident coverage plan, at my expense, or the equivalent in a family insurance policy. I certify that he/she is in compliance with this regulation.

Date __________ Parent/Guardian Signature __________

Physical Examination

(to be completed by Health Care Provider)

Name ______________________________ Date of Birth ______________

Height ____________ Weight ____________ BMI ____________ BP ______/______

MEDICAL	Normal	Abnormal Findings	Initials
General Appearance			
Skin			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Chest			
Lungs			
Abdomen			
Genitalia			
MUSCULOSKELETAL			
Neck			
Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

IMMUNIZATIONS:

All immunizations are current .... **Y N**

Immunizations given today: ______________________________

Health Care Providers Certification for Athletic Participation

I hereby certify that ____________________ has been examined, and this student is:

☐ Cleared for all sports

☐ Cleared after completing evaluation/rehabilitation for: ____________________

☐ **NOT** cleared for: (please circle)

Baseball	Basketball	Cross Country	Football	Gymnastics	Cheer/Poms
Soccer	Softball	Tennis	Track and Field	Wrestling	Golf
Swimming	Volleyball				

Reason: ______________________________

Recommendation: ______________________________

Name of Health Care Provider (print) ____________________ Date ____________

Address ____________________ Phone ____________

Signature of HCP ____________________ M.D., D.O., NP, PA-C, D.C. Spc. # ________

(valid for 365 days unless rescinded)

ADAPTED: American academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine