

EL TORO HIGH SCHOOL SPORTS SCREENING ASSESSMENT

STUDENT'S NAME (PRINT) _____ DATE OF BIRTH _____
 ADDRESS _____ SEX: M F GRADE _____
 CITY _____ STATE _____ ZIP _____ PHONE _____

WEIGHT: _____ HEIGHT: _____ BLOOD PRESSURE: _____ / _____
 PULSE: _____ RESP: _____

CIRCLE APPROPRIATE FINDINGS:

LUNGS: CLEAR WHEEZING RALES OTHER _____ PEAK FLOW _____
 CARDIAC: RRRsM: MURMURS _____/6: ARRHYTHMIAS OTHER _____
 ABDOMEN: NORMAL (SOFT, BOWELL SOUNDS NL, NO MASSES) OTHER _____
 HERNIAS: (INGUINAL, MALES ONLY) FOUND NOT FOUND
 NECK: (NORMAL ORN) YES NO (CHIN TO CHEST, 90 DEG ROTATION, EAR TO SHLD R AND L, 45 DEG EXT)
 MUSCULOSKELETAL: (CHECK ASYMMETRIC ROM, MUSCLE IMBALANCE, JOINT LAXITY, DEFORMITY, PAIN/SWELLING)

CIRCLE ANY JOINT WITH ABNORMAL FINDINGS AND ELABORATE:

SHOULDER _____
 ELBOW _____
 WRIST _____
 HAND _____
 BACK _____
 HIPS _____
 KNEES _____
 ANKLES _____
 FEET _____

EVALUATION (CIRCLE ONE)

1. UNLIMITED ATHLETIC PARTICIPATION
2. MAY PARTICIPATE PENDING FURTHER EVALUATION
Referral to: _____
3. LIMITED ATHLETIC PARTICIPATION
Orthopedic limitations
4. ATHLETIC PARTICIPATION DENIED
Reasons _____

DATE OF EXAM (Mandatory) _____
 SIGNATURE OF EXAMINING/EVALUATING PHYSICIAN _____
 PHYSICIAN STAMP _____ DATE: (Mandatory) _____

SPORTS SCREENING HEALTH QUESTIONNAIRE TO BE FILLED OUT AND SIGNED BY PARENT

EMERGENCY CONTACT PERSON _____
 RELATIONSHIP _____ PHONE () _____
 PRIMARY CARE PHYSICIAN _____
 ADDRESS _____ PHONE () _____
 DATE OF LAST VISIT/PHYSICAL _____

MEDICAL HISTORY: It is important this form be filled out completely and accurately by a parent or legal guardian. It is an important part of providing health care to your child, and allows the physicians focus on important areas specific to your child. Please circle all appropriate answers.

ALLERGIES? Y/N **DRUGS:** Penicillin Sulfa Other _____
ENVIRONMENTAL: Bee stings Pollen Dust Other _____
FOOD: _____
 What happens during the allergic reaction? _____

Current Prescription medications? _____ Y/N
 Reason for medication _____
 Bone, joint, tendon or ligament injuries requiring medical attention? _____ Y/N
 Explanation _____
 Head, neck or back injuries/problems? _____ Y/N
 Explanation _____
 Any previous surgery? _____ Y/N
 Explanation _____

Any previous hospitalizations? _____ Y/N
 Explanation _____
 Any history of loss of consciousness? _____ Y/N
 If "Yes", was the athlete: knocked out fainted when? _____
 Any history of seizures? _____ Y/N
 Explanation _____

Wear glasses contacts? _____ Y/N
 Any history of asthma? _____ Y/N If "Yes" is an inhaler required?
 Has your child ever had any PE class limitations? _____ Y/N
 Explanation _____

Are immunizations current? _____ Y/N
 Any uncorrected visual condition that may impair sports participation? _____ Y/N
 Any significant medical problems such as: (Circle all appropriate answers)

- Loss of an organ (i.e. kidney, spleen, eye, etc.)
- Bleeding problems (anemia, sickle cell, hemophilia, etc.)
- Respiratory problems (i.e. shortness of breath, asthma, tuberculosis, collapsed lungs, etc.)
- Cardiac problems (i.e. murmur, etc.)
- Psychiatric problems requiring medical treatment
- Leukemia
- Menstrual problems

Any family history of: (Circle all appropriate answers)
 Diabetes requiring insulin Bleeding problems Heart problems Other _____
 Is there any other medical condition that you know of that should be brought to the attention of the physicians or any reason why the athlete should be limited or withheld from athletic participation? _____ Y/N
 Explanation _____

I hereby certify that the above information is true and correct.

Parent Signature _____ Date _____ 4/11