

MEDICAL EXAMINATION – To Be Completed By Medical Doctor or his designee

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
		Arrhythmia
		Murmur
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		
PHYSICAL MATURITY (TANNER STAGE)		1 2 3 4 5

HEIGHT _____ WEIGHT _____
 BLOOD PRESSURE _____ PULSE _____
 HCT/HGB _____
 URINALYSIS: _____ Protein _____ Blood _____ Glucose
 VISUAL ACUITY: _____ RIGHT _____ LEFT
 CORRECTED TO: _____ RIGHT _____ LEFT
 HEARING: _____

BODY FAT (Optional) = _____ %
CHOLESTEROL (Optional) = _____

LAST TETANUS BOOSTER	Date: _____
LAST MEASLES (MMR) BOOSTER	Date: _____
OTHER IMMUNIZATIONS _____	Date: _____

SUMMARY: _____

ORTHOPEDIC EXAM

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

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

RECOMMENDATIONS

WEIGHT LOSS/GAIN _____	MEDICATIONS _____
STRENGTHENING _____	SPECIAL EQUIPMENT _____
STRETCHING _____	BRACING/TAPING _____
CONDITIONING (Endurance) _____	

I certify that on this date I have examined this student 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 compete in supervised athletic activities except those listed below:

 SIGNATURE OF MEDICAL DOCTOR DATE TELEPHONE MEDICAL DOCTOR (PRINT OR STAMP)

**PLYMOUTH BOARD OF EDUCATION
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 DOCTOR'S OFFICE.**

NAME _____ AGE _____ SEX _____ SCHOOL _____
 ADDRESS _____ PHONE _____ GRADE _____
 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	_____ Bleeding Disorders	_____ Diabetes	_____ Epilepsy (Seizures)
_____ Hepatitis (liver disease)	_____ Hypertension (High Blood Pressure)	_____ Sickle Cell Anemia	_____ (Other) _____
_____ Mononucleosis-Yr _____	_____ Kawasaki's Disease	_____ Handicap (Describe) _____	

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

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

Have you ever been hospitalized for medical or surgical reasons? → → → → → → → → → → → → → → → → YES NO
 If yes, provide the following information:

REASON	YEAR	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more?

INJURED AREA (Knee, Hamstring, Neck, Shin, etc.)	YEAR	SIDE (R, L)	TYPE (Fracture, Sprain, Swelling, Pinched Nerve, etc.)	RESOLVED YES NO
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 _____