

PRE-PARTICIPATION SPORTS SCREENING PHYSICAL EXAM (STATION FORM)  
DELTA COUNTY AREA SCHOOLS

(Complete in INK)

DATE: \_\_\_\_\_, SCHOOL: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE \_\_\_\_ FEMALE \_\_\_\_  
(Last) (First)

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ GRADE (in the FALL): \_\_\_\_\_

PARENT'S NAME(S): \_\_\_\_\_ FAMILY DOCTOR: \_\_\_\_\_  
(Or the Office Name)

PHONES: \_\_\_\_\_  
(home) (work)

**WHICH SPORTS ARE YOU INTERESTED IN FOR THE COMING YEAR?**

Football     Wrestling     Track     Cheerleading     Volleyball     Golf     Swim  
 Basketball     Cross Country     Hockey     Tennis     Gymnastics     Softball

**MEDICAL HISTORY (Must be reviewed and signed by Parent or Guardian)**

(Please check) **YES** **NO**

- |   |           |       |
|---|-----------|-------|
| 1. Have you ever been told you couldn't participate in sports?  | 1. _____  | _____ |
| 2. Are you currently being treated for an injury or illness?  | 2. _____  | _____ |
| 3. Are you blind in either eye?   | 3. _____  | _____ |
| 4. Do you have any eye problems not correctable by glasses or contacts?                                   | 4. _____  | _____ |
| 5. Have you ever passed out or fainted during or after exercise?  | 5. _____  | _____ |
| 6. Have any family members under age 50 died suddenly of a heart problem?                                 | 6. _____  | _____ |
| 7. Do you get tired or short of breath more quickly than your friends with exercise?                      | 7. _____  | _____ |
| 8. Does your heart race uncontrolled or skip beats during exercise?                                       | 8. _____  | _____ |
| 9. Have you ever had high blood pressure, a heart murmur or heart problem?                                | 9. _____  | _____ |
| 10. Do you have asthma?   | 10. _____ | _____ |
| 11. Have you ever been knocked unconscious, had a skull fracture, or concussion?                          | 11. _____ | _____ |
| 12. Have you broken any bones?  | 12. _____ | _____ |
| 13. Have you had any sprains, dislocations, or torn ligaments?  | 13. _____ | _____ |
| 14. Have you ever had a neck injury, or severe pain or numbness in the neck or arms while playing sports? | 14. _____ | _____ |
| 15. Have you ever had an injury that has kept you out of a sport for more than 2 weeks?                   | 15. _____ | _____ |
| 16. Have you had any bone or joint operations?  | 16. _____ | _____ |
| 17. Have you ever had any kidney disease or injury, blood in the urine, or painful urination?             | 17. _____ | _____ |
| 18. Have you had Mononucleosis ("mono")? When? _____  | 18. _____ | _____ |
| 19. Have you had any other surgery?   | 19. _____ | _____ |
| 20. Have you been hospitalized for anything not mentioned above?  | 20. _____ | _____ |
| 21. Do you have seizures or epilepsy?   | 21. _____ | _____ |
| 22. Do you have Diabetes?   | 22. _____ | _____ |
| 23. Are you taking any medications?   | 23. _____ | _____ |
| 24. Do you use alcohol, tobacco, inhalants, or other drugs?   | 24. _____ | _____ |
| 25. Do you use steroids, amino acids, creatine, or other performance enhancing substances?                | 25. _____ | _____ |

**DESCRIBE details of any YES answers:**

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(If you have any **special letters** from your physicians that have been needed in the past to explain a medical problem or to release you to play sports, **please attach them to this form.**)

I have carefully reviewed this Medical History, and declare it to be correct to the best of my knowledge. I believe that this student is in satisfactory physical and emotional condition to participate in athletics unless otherwise noted. **(The physical evaluation cannot be performed without this completed, and signed, form.)** I understand that this is a SCREENING EVALUATION ONLY, and not a detailed and complete examination. I also understand that health care volunteers provide these screening evaluations free of charge, as a community service.

Signatures: \_\_\_\_\_ Date: \_\_\_\_\_  
PARENT or GUARDIAN STUDENT

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**PHYSICAL EXAM**

NAME: \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_

BP: #1: \_\_\_\_\_ #3: \_\_\_\_\_  
(<135/85) #2: \_\_\_\_\_ #4: \_\_\_\_\_

PULSE: #1: \_\_\_\_\_ #3: \_\_\_\_\_  
(<100) #2: \_\_\_\_\_ #4: \_\_\_\_\_

	NORMAL:	ABNORMALS (describe):	RECOMMENDATIONS:	CLEARED?	By:
<u>HEENT</u> (1-4)				Y N	
Eyes	[ ]			Y N	
Ears	[ ]			Y N	
Nose/Throat	[ ]			Y N	_____
<u>CARDIO-PULM.</u> (1, 2, 5-10, 20-25)				Y N	
Heart	[ ]			Y N	
Lungs	[ ]			Y N	_____
<u>ORTHO</u> (1, 2, 11-16)				Y N	
Neck	[ ]			Y N	
Back	[ ]			Y N	
Shoulders	[ ]			Y N	
Upper extrem.	[ ]			Y N	
Lower extrem.	[ ]			Y N	
Other	[ ]			Y N	_____
<u>ABDOMEN</u> (1, 2, 17-20) [ ]				Y N	_____
<u>MALES</u> (1, 2, 17-18) [ ]				Y N	_____
(Inguinal canals, scrotum)					
<u>SKIN</u> (Optional): [ ]				Y N	_____

PT/RT Notes:

REFERRAL TO: PT or RT for: \_\_\_\_\_ →

CLEARANCE

CLEARED WITHOUT RESTRICTION  RECOMMENDATIONS: \_\_\_\_\_

CLEARED AFTER: \_\_\_\_\_ Documentation / \_\_\_\_\_ Evaluation / \_\_\_\_\_ Rehabilitation For: \_\_\_\_\_

NOT CLEARED FOR: \_\_\_\_\_ COLLISION  
 \_\_\_\_\_ CONTACT  
 \_\_\_\_\_ NON-CONTACT: \_\_\_\_\_ Strenuous; \_\_\_\_\_ Moderately Strenuous; \_\_\_\_\_ Non strenuous

Due to: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ M.D. / D.O. Date: \_\_\_\_\_

Note: Supply a copy of this Physical to both the Primary Care Physician and to the School Athletic Office.