STUDENT HEALTH REVIEW/EXAM

To be completed by parent or guardian.

Student Last Name | **Student First Name** | **MI** | **Date of birth** | **Grade**

_____/_____/_____

Address | **City** | **Zipcode**

Phone | **Emergency Phone** | **Date of last physical exam**

_____/_____/_____

Are your immunizations up to ☐ Yes ☐ No | **Last tetanus shot** _____/_____/____ | **Last measles shot** _____/_____/___ | **Last TB skin test** _____/_____/___

		YES	NO
1.	Have you ever been hospitalized?	☐	☐
2.	Have you been diagnosed with COVID-19?	☐	☐
3.	Have you ever had surgery?	☐	☐
4.	Are you presently taking any medications, pills or supplements?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
6.	Have you ever been dizzy during or after exercise?	☐	☐
7.	Have you ever had chest pain during or after exercise?	☐	☐
8.	Do you tire more quickly than your friends during exercise?	☐	☐
9.	Have you ever had high blood pressure?	☐	☐
10.	Have you ever been told that you have a heart murmur?	☐	☐
11.	Have you ever had racing of your heart or skipped beats?	☐	☐
12.	Has anyone in your family died of heart problems or sudden death before age 50?	☐	☐
13.	Do you have any skin problems *(itching, rashes, acne)*?	☐	☐
14.	Have you ever had a head injury?	☐	☐
15.	Have you ever had a concussion? If yes, how many_____	☐	☐
16.	Have you ever been knocked out or unconscious?	☐	☐
17.	Do you suffer from migraines?	☐	☐
18.	Have you ever had a seizure?	☐	☐
19.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
20.	Have you ever had heat or muscle cramps?	☐	☐
21.	Have you ever been dizzy or passed out in the heat?	☐	☐
22.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
23.	Do you use any medical assistant devices *(insulin pump, prosthetic, implanted device, etc.)*?	☐	☐
24.	Have you ever had problems with your eyes or vision?	☐	☐
25.	Do you wear glasses or contacts or protective eye wear?	☐	☐
26.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints?	☐	☐
	___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand		
27.	Are you Diabetic?	☐	☐
28.	Are you Asthmatic?	☐	☐
29.	Have you had any medical problem or injury since your last evaluation?	☐	☐
30.	Do you have any allergies *(medicine, bees or other stinging insects)*??	☐	☐
	List all allergies: _____		
31.	Have you ever had other medical problems *(infectious mononucleosis, etc.)*?	☐	☐
32.	When was your first menstrual period? _____		
	When was your last menstrual period? _____		
	What was the longest time between your periods last year? _____		
33.	Explain all "yes" answers: _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH REVIEW/EXAM

To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic

This form to be sent to the school (do not send to ASAA)

Student Last Name	Student First Name	MI	Date of birth	Grade
			_____/_____/_____	

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of M.D., D.O. P.A., ANP or DC (circle)	Signature	Date
		_____/_____/_____

Address	Phone