

# EAST GRANBY PUBLIC SCHOOLS

## Part I SPORTS PARTICIPATION HEALTH RECORD AND CONSENT

To be completed by athlete and/or parent prior to doctor's visit. **All sections must be completed. Sports physicals and consents are valid for one year from the date of the physical and consent.** This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations.

Name: \_\_\_\_\_ Age/Yrs.: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Sports over next 12 months: \_\_\_\_\_

### Part A – Health History

		Yes	No			Yes	No
1. Have you ever had an illness that:				5. Are you able to run ½ mile (2 times around a track) without stopping?			
a. required you to stay in the hospital?	<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
b. lasted longer than a week?	<input type="checkbox"/>		<input type="checkbox"/>	6. Do you:			
c. caused you to miss 3 days or more of practice or competition?	<input type="checkbox"/>		<input type="checkbox"/>	a. wear glasses or contacts?	<input type="checkbox"/>		<input type="checkbox"/>
d. is chronic? (i.e., asthma, diabetes, seizure disorder, etc.)	<input type="checkbox"/>		<input type="checkbox"/>	b. Wear dental bridges, plates or braces?	<input type="checkbox"/>		<input type="checkbox"/>
e. required an operation?	<input type="checkbox"/>		<input type="checkbox"/>	7. Have you ever had a heart murmur, high blood pressure, or a heart abnormality?	<input type="checkbox"/>		<input type="checkbox"/>
If yes, please indicate:				8. Do you have any allergies to any medicine, foods or bee stings.	<input type="checkbox"/>		<input type="checkbox"/>
a. Reason for hospitalization _____				9. Are you missing a kidney?	<input type="checkbox"/>		<input type="checkbox"/>
b. Type of surgery _____				10. List all medications you are presently taking and what condition the medication is for.			
2. Have you ever had an injury that:				a. _____			
a. required you to go to an emergency room or see a doctor?	<input type="checkbox"/>		<input type="checkbox"/>	b. _____			
b. required you to stay in the hospital?	<input type="checkbox"/>		<input type="checkbox"/>	c. _____			
c. required x-rays?	<input type="checkbox"/>		<input type="checkbox"/>	<b>For Women</b>			
d. caused you to miss 3 days or more of school, practice or competition?	<input type="checkbox"/>		<input type="checkbox"/>	a. At what age did you experience your first menstrual period? _____			
e. required an operation?	<input type="checkbox"/>		<input type="checkbox"/>	b. In the last year what is the longest time you have gone between periods? _____			
If yes, please indicate:				<b>Explain all "YES" Answers:</b>			
a. Type of injury _____				_____			
b. Type of surgery _____				_____			
3. Have any members of your family, under age 50 had a heart attack, heart problem, or died unexpectedly?	<input type="checkbox"/>		<input type="checkbox"/>	_____			
4. Have you ever been?				_____			
a. dizzy or passed out during or after exercise?	<input type="checkbox"/>		<input type="checkbox"/>	_____			
b. unconscious or had a concussion?	<input type="checkbox"/>		<input type="checkbox"/>	_____			

### Part II

**AUTHORIZATION FOR HEALTH CARE SERVICES:** I/we hereby designate the health services personnel, the team coach, or his/her designee to act on my/our behalf to authorize such hospitalization, medical attention, surgery and any other health care services as may be recommended in an emergency because of illness or injuries sustained by this student while preparing for or participating in interscholastic athletics. I/we hereby assume all financial responsibility for all health care services so provided. I/we request that we be contacted within a reasonable time in the event of illness or injuries to this student requiring health care services.

Work Phone Mother: \_\_\_\_\_

Work Phone Father: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Insurance: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature of Parent/Guardian

Date

**MEDICAL EXAMINATION – TO BE COMPLETED BY MEDICAL DOCTOR OR HIS/HER DESIGNEE**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

	Normal	Abnormal Findings	
APPEARANCE			HEIGHT: _____ WEIGHT: _____
SKIN			BLOOD PRESSURE: _____ PULSE: _____
HEENT			HGT/HGB: _____
RESPIRATORY			URINALYSIS: ___ Protein ___ Blood ___ Glucose
			VISUAL ACUITY: _____ Right _____ Left
			CORRECTED TO: _____ Right _____ Left
	Arrhythmia		HEARING: _____
	Murmur		
ABDOMEN			BODY FAT (optional) = _____ %
SPINE (Scoliosis)			CHOLESTEROL (option) = _____ %
NEUROLOGICAL			LAST TETANUS BOOSTER: _____ Date: _____
GENITALIA (Hernia)			LAST MEASLES (MUMPS) BOOSTER: _____ Date: _____
PHYSICAL MATURITY	(Tanner Stage) 1 2 3 4 5		

**ORTHOPEDIC EXAM**

**MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY:**

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

**RECOMMENDATIONS**

WEIGHT LOSS/GAIN: \_\_\_\_\_ MEDICATIONS: \_\_\_\_\_  
 STRENGTHENING: \_\_\_\_\_ SPECIAL EQUIPMENT: \_\_\_\_\_  
 STRETCHING: \_\_\_\_\_ BRACING/PACING: \_\_\_\_\_  
 CONDITIONING: \_\_\_\_\_

I certify that on this date I have examined this student and reviewed his/her history 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 complete in supervised athletic activities except those listed below.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature of Medical Doctor                      Date of Exam                      Telephone                      Medical Doctor (Print)

This form was developed and approved by Connecticut Chapter, Committee on School Health – American Academy of Pediatrics Connecticut Chapter, Committee on Sports Medicine – American Academy of Pediatrics – The Connecticut State Medical Society Committee on the Medical Aspects of Sports.