

Sport Physical Evaluation

Juneau School District

Health History

Name _____ Sex _____ Age _____

Date of Birth _____ Grade _____

School _____ Sport(s) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="radio"/> | <input type="radio"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="radio"/> | <input type="radio"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="radio"/> | <input type="radio"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="radio"/> | <input type="radio"/> |
| 5. Have you ever passed out or nearly passed out with exercise? | <input type="radio"/> | <input type="radio"/> |
| 6. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="radio"/> | <input type="radio"/> |
| 7. Does your heart race or skip beats during exercise? | <input type="radio"/> | <input type="radio"/> |
| 8. Has a doctor ever told you that you have (check all that apply): | | |
| <input type="radio"/> High blood pressure <input type="radio"/> A heart murmur | | |
| <input type="radio"/> High cholesterol <input type="radio"/> A heart infection | | |
| 9. Does anyone in your family have a heart problem? | <input type="radio"/> | <input type="radio"/> |
| 10. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="radio"/> | <input type="radio"/> |
| 11. Have you ever spent the night in a hospital? | <input type="radio"/> | <input type="radio"/> |
| 12. Have you ever had surgery? | <input type="radio"/> | <input type="radio"/> |
| 13. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: | | |
| 14. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | | |

| | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/Fingers | Chest |
| Upper Back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes |

- | | Yes | No |
|--|-----------------------|-----------------------|
| 15. Do you regularly use a brace or assistive device? | <input type="radio"/> | <input type="radio"/> |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| 17. Is there anyone in your family who has asthma? | <input type="radio"/> | <input type="radio"/> |
| 18. Have you ever used an inhaler or asthma medicine? | <input type="radio"/> | <input type="radio"/> |
| 19. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="radio"/> | <input type="radio"/> |
| 20. Have you had infectious mononucleosis (mono) within the last month? | <input type="radio"/> | <input type="radio"/> |
| 21. Do you have any rashes, pressure sores, or other skin problems? | <input type="radio"/> | <input type="radio"/> |
| 22. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="radio"/> | <input type="radio"/> |
| 23. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="radio"/> | <input type="radio"/> |
| 24. Have you had any problems with your eyes or vision? | <input type="radio"/> | <input type="radio"/> |
| 25. Are you trying to gain or lose weight? | <input type="radio"/> | <input type="radio"/> |
| 26. Has anyone recommended you change your weight or eating habits? | <input type="radio"/> | <input type="radio"/> |
| 27. Do you have any concerns that you would like to discuss with a doctor? | <input type="radio"/> | <input type="radio"/> |

FEMALES ONLY

- | | | |
|--|-----------------------|-----------------------|
| 28. Have you ever had a menstrual period? | <input type="radio"/> | <input type="radio"/> |
| 29. How old were you when you had your first menstrual period? _____ | | |
| 30. Do you have monthly periods? | <input type="radio"/> | <input type="radio"/> |

Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____

This form was filled out by: self parent/guardian

Sport Physical Evaluation

Juneau School District

Examination Form

To be completed by physician, physician assistant, or advance nurse practitioner

Name _____ Date of Exam _____

Height _____ Weight _____ Pulse _____ BP _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Glasses/ Contacts

| | NORMAL | ABNORMAL FINDINGS | INITIALS |
|------------------------|--------|-------------------|----------|
| MEDICAL | | | |
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Lymph nodes | | | |
| Heart | | | |
| Lungs | | | |
| GI | | | |
| Genitourinary (males) | | | |
| Skin | | | |
| Neuro | | | |
| MUSCULOSKELETAL | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

- Cleared
- Cleared after completed evaluation/rehabilitation for _____
- Not cleared: Explain: _____

Name of MD PA ANP (circle which) (print/type) _____

Phone: _____

Signature of provider _____ Date _____