EL TORO HIGH SCHOOL
SPORTS SCREENING ASSESSMENT

STUDENT'S NAME (PRINT)______________________________ **DATE OF BIRTH**___________

ADDRESS____ **SEX: M F GRADE**______

CITY___________________________ **STATE**______ **ZIP**_________ **PHONE**_______________

WEIGHT:___________ **HEIGHT:**___________ **BLOOD PRESSURE:**________/________
PULSE:__________ **RESP:**___________

CIRCLE APPROPRIATE FINDINGS:
LUNGS: CLEAR WHEEZING RALES OTHER__________**PEAK FLOW**________
CARDIAC: RRRsM: MURMURS__________/6: **ARRTHYMIAS OTHER**_______
ABDOMEN: NORMAL (SOFT, BOWELL SOUNDS NL, NO MASSES) **OTHER**_____________________
HERNIAS: (INGUINAL, MALES ONLY) **FOUND NOT FOUND**
NECK: (NORMAL ORM) **YES NO** (CHIN TO CHEST, 90 DEG ROTATION, EAR TO SHLD R AND L, 45 DEG EXT)
MUSCULOSKELETAL: (CHECK ASYMMETRIC ROM, MUSCLE IMBALANCE, JOINT LAXITY, DEFORMITY, PAIN/SWELLING)

CIRCLE ANY JOINT WITH ABNORMAL FINDINGS AND ELABORATE:
SHOULDER ____
ELBOW ____
WRIST ____
HAND ____
BACK ____
HIPS ____
KNEES ____
ANKLES ____
FEET ____

EVALUATION (CIRCLE ONE)
1. **UNLIMITED ATHLETIC PARTICIPATION**
2. **MAY PARTICIPATE PENDING FURTHER EVALUATION**
   Recommendation for further W/U ______________________________
   Referral to: ______________________________
3. **LIMITED ATHLETIC PARTICIPATION**
   Orthopedic limitations ______________________________
4. **ATHLETIC PARTICIPATION DENIED**
   Reasons ______________________________

DATE OF EXAM (Mandatory) ______________________________

SIGNATURE OF EXAMINING/EVALUATING PHYSICIAN ___________________________
DATE: (Mandatory) ________________________

PHYSICIAN STAMP

SPORTS SCREENING HEALTH QUESTIONNAIRE
TO BE FILLED OUT AND SIGNED BY PARENT

EMERGENCY CONTACT PERSON ______________________________________
RELATIONSHIP ___________________________ **PHONE** ( )________________
PRIMARY CARE PHYSICIAN ______________________________________
ADDRESS ______________________________ __**PHONE** ( )________________
DATE OF LAST VISIT/PHYSICAL _______________

MEDICAL HISTORY: It is important this form be filled out completely and accurately by a parent or legal guardian. It is an important part of providing health care to your child, and allows the physicians focus on important areas specific to your child. Please circle all appropriate answers.

ALLERGIES? Y/N **DRUGS:** Penicillin Sulfa Other______________________
ENVIRONMENTAL: Bee stings Pollen Dust Other___________
FOOD: ______________________________________
What happens during the allergic reaction? ____________________

Current Prescription medications? Y/N
Reason for medication______________________________________

Bone, joint, tendon or ligament injuries requiring medical attention? Y/N
Explanation______________________________________

Head, neck or back injuries/problems? Y/N
Explanation ______________________________________

Any previous surgery? Y/N
Explanation ______________________________________

Any previous hospitalizations? Y/N
Explanation______________________________________

Any history of loss of consciousness? Y/N
If "Yes", was the athlete: knocked out fainted when?______________________

Any history of seizures? Y/N
Explanation ______________________________________

Wear glasses contacts? Y/N

Any history of asthma? Y/N If "Yes" is an inhaler required? Y/N

Has your child ever had any PE class limitations? Y/N
Explanation ______________________________________

Are immunizations current? Y/N

Any uncorrected visual condition that may impair sports participation? Y/N

Any significant medical problems such as: **(Circle all appropriate answers)**
- Loss of an organ (i.e. kidney, spleen, eye, etc.)
- Bleeding problems (anemia, sickle cell, hemophilia, etc.)
- Respiratory problems (i.e. shortness of breath, asthma, tuberculosis, collapsed lungs, etc.)
- Cardiac problems (i.e. murmur, etc.)
- Psychiatric problems requiring medical treatment
- Leukemia
- Menstrual problems

Any family history of: **(Circle all appropriate answers)**
Diabetes requiring insulin Bleeding problems Heart problems Other ____________

Is there any other medical condition that you know of that should be brought to the attention of the physicians or any reason why the athlete should be limited or withheld from athletic participation? Y/N
Explanation ______________________________________

I hereby certify that the above information is true and correct.

Parent Signature ________________________________**Date** ___________________

4/11