ALBIANI MIDDLE SCHOOL ATHLETIC SCREENING EXAM

PART 1 (TO BE COMPLETED BY STUDENT AND PARENTS OR GUARDIAN)

LAST NAME		FIRST NAME		GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT NUMBER

HEALTH HISTORY (Must be completed prior to the examination)

	Yes	No	Has this student had any:
1	☐	☐	Chronic or recurrent illness?
2	☐	☐	Illness lasting over 1 week?
3	☐	☐	Hospitalizations?
4	☐	☐	Surgery other than removal of tonsils?
5	☐	☐	Missing organs (eye, kidney, testicle)?
6	☐	☐	Allergies (medicines, ***insect bites***, food)
7	☐	☐	Problems with heart or blood pressure?
8	☐	☐	Chest pain or severe shortness of breath with exercise?
9	☐	☐	Dizziness or fainting with exercise?
10	☐	☐	Fainting, bad headaches, or convulsions?
11	☐	☐	Concussion or loss of consciousness?
12	☐	☐	Heat exhaustion, heatstroke, or other problems with heat?
13	☐	☐	Racing heart, skipped, irregular heartbeats, or heart murmur?
14	☐	☐	Seizures?
15	☐	☐	Muscle cramps?

	Yes	No	Does this student:
16	☐	☐	Wear eyeglasses or contact lenses?
17	☐	☐	Wear dental bridges, braces, or plates?
18	☐	☐	Take any medications? Please list

	Yes	No	Is there any history of:
19	☐	☐	Injuries requiring physician treatment?
20	☐	☐	Neck or back injury?
21	☐	☐	Knee injury?
22	☐	☐	Shoulder or elbow injury?
23	☐	☐	Ankle injury?
24	☐	☐	Other serious joint injury?
25	☐	☐	Broken bones (fractures)?

	Yes	No	Further history
26	☐	☐	Is there any reason why this student should not participate in sports?
27	☐	☐	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
28	☐	☐	Has any family member had a heart attack at less than 55 years of age?

Explanation of all "Yes" answers:

Date of last known tetanus (lockjaw) shot: ________________

PARENT OR GUARDIAN'S ACKNOWLEDGEMENT AND PERMISSION: I have reviewed and agree with the above information. I know of no reason why the above named student may not participate and represent his or her school in supervised athletic activities. Therefore, I give my permission for this student to participate in athletics and guarantee that he/she has sufficient medical insurance. Also, I authorize the doctor to perform this screening examination.

PRINT NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS	WORK PHONE	HOME PHONE	DATE
PHYSICIAN NAME	OFFICE PHONE	MEDICAL INSURANCE COMPANY & NUMBER	

PART II (TO BE COMPLETED BY THE EXAMINING PHYSICIAN)

	NORMAL	ABNORMAL (Describe)	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse: After Ex:
Abdomen			BP:
Genitalia/hernia (males)			***Recommendations:***
Musculoskeltal			☐ Unlimited Participation
a. neck			☐ Participation limited to specific sports
b. spine			
c. shoulders			☐ Clearance withheld pending further evaluation
d. arms, hands			
e. hips			☐ No athletic participation
f. thighs			
g. knees			One of the above must be ***checked.***
h. ankles			
I. feet			

Comments:

PHYSICIAN SIGNATURE **DATE**

NOTICE: THIS EXAMINATION DOES NOT CONSTITUTE A COMPLETE PHYSICAL EXAMINATION. **It does, on this date, based on the observations of the doctor, meet the requirements for the herein named child to participate in school sports activities. If you have any health concerns related to your child, be sure to bring those concerns specifically to the attention of the doctor.**