HISTORY FORM (Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Date _____

Medications: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below:

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Do you get lightheaded or feel more short of breath than expected during exercise, OR do you get more tired or short of breath more quickly than your friends?		
10. Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?		
12. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
13. Has anyone in your family had unexplained fainting, unexplained seizures, or near-drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
14. Have you ever had an injury to a bone, muscle, ligament, or tendon?		
15. Have you ever had any broken or fractured bones or dislocated joints?		
16. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
17. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
18. Do you regularly use a brace, orthotics, or other assistive device?		
19. Do you have a bone, muscle, or joint injury that still bothers you?		
20. Do any of your joints become painful, swollen, feel warm, or look red?		
21. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**Yes**	**No**
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
23. Have you ever used an inhaler or taken asthma medicine?		
24. Were you born without or are you missing a kidney, an eye, a testicle (males only), your spleen, or any other organ?		
25. Do you have groin pain or a painful bulge or hernia in the groin area?		
26. Have you had infectious mononucleosis (mono) within the last month?		
27. Do you have any rashes, pressure sores, or other skin problems?		
28. Have you had herpes or MRSA skin infection?		
29. Have you ever had a head injury or concussion?		
30. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
31. Do you have a history of seizure disorder?		
32. Do you have headaches with exercise?		
33. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
34. Have you ever been unable to move your arms or legs after being hit or falling?		
35. Have you ever become ill while exercising in the heat?		
36. Do you get frequent muscle cramps when exercising?		
37. Do you or someone in your family have sickle cell trait or disease?		
38. Have you had any problems with your eyes or vision?		
39. Have you had any eye injuries?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you trying to or has anyone recommended that you gain or lose weight?		
43. Are you on a special diet or do you avoid certain types of foods?		
44. Have you ever had an eating disorder?		
45. Do you have any concerns that you would like to discuss with a doctor?		

Females only:

46. Have you ever had a menstrual period? ☐ Y ☐ N
47. How old were you when you had your first menstrual period? _____
48. How many periods have you had in the last 12 months? _____

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_____

School nurse: Immunization Compliance ☐ Y ☐ N Initials: _____

THE ATHELETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM (Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Date _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers below:

_____
_____
_____
_____
_____

Please indicate if you have ever had any of the following:

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers below:

_____
_____
_____
_____
_____

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_____

Reviewed by school nurse (initials) _____

Physical Examination Form (Note: This form is completed by a licensed medical provider to determine clearance for athletic participation.)

Name _____ Date of birth _____

PROVIDER

1. Please consider additional questions on more sensitive issues

Do you feel stressed out or under a lot of pressure?

Do you ever feel sad, hopeless, depressed, or anxious?

Do you feel safe at your home or residence?

Have you ever tried cigarettes, chewing tobacco, snuff, or dip?

During the past 30 days, did you use chewing tobacco, snuff, or dip?

Do you drink alcohol or use any other drugs?

Have you ever taken anabolic steroids or used any other performance supplement?

Have you ever taken any supplements to help you gain or lose weight or improve your performance?

Do you wear a seat belt, use a helmet, and use condoms?

2. Please consider reviewing questions on cardiovascular symptoms (questions 5–13).

EXAMINATION		
Height_____ Weight _____ BP _____/_____ Pulse _____ RR _____ SpO2 _____		
Vision: R 20/_____ L 20/_____ Corrected ☐ Y ☐ N Hearing: R 500 1000 2000 4000 @ _____dB L 500 1000 2000 4000 @ _____dB		
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 • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		
• Duck-walk, single-leg hop		

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

- ☐ Cleared for all sports without restrictions
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- ☐ Not cleared

  Reason _____

  Recommendations _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of examining provider: (print/type) _____

Signature of examining provider:_____ Date of exam _____

SAU Policy Committee: Adopted – October 15, 2020

Clarksville School Board: Adopted – December 14, 2020
Colebrook School Board: Adopted – December 15, 2021
Columbia School Board: Adopted – January 6, 2021
Pittsburg School Board: Adopted – December 1, 2020
Stewartstown School Board: Adopted – January 12, 2021