

Athletic Screening

Last Name: _____ First Name _____ Grade Next Year: _____

Sports: _____

Parents complete this section

Athlete Injury History

- ___ Concussion/Knocked out
- ___ Any neck injury
- ___ Shoulder L / R
- ___ Back
- ___ Hip/Thigh
- ___ Knee: ligaments, bone, cartilage
- ___ Shin splints
- ___ Ankle/foot
- ___ Muscle tear/strain
- ___ Pinched nerve ("stingers")
- ___ Other injuries _____
- ___ Have you ever had surgery? If so, what kind? _____
- ___ Have you ever been in the hospital for a health problem? If so, what kind? _____
- ___ Has a doctor ever recommended that you not participate in sports? If so, why? _____
- ___ Allergies: Please list _____

Athlete Medical History

- ___ Serious or chronic health problems
- ___ Heart murmur
- ___ Chest pains
- ___ Diabetes
- ___ Seizures/epilepsy
- ___ Fainted with exercise
- ___ Kidney disease/blood in urine
- ___ Single/missing organ (testicle, eye, kidney)
- ___ Asthma
- ___ Mononucleosis/enlarged spleen
- ___ Hernia/rupture

I grant permission for this evaluation. I understand this is a limited exam and does not prevent injury or sudden death. The purpose of this form is to screen young adults who may be exhibiting symptoms of heart disease that could cause their heart to stop suddenly in an athletic event. Please question your child thoroughly about the symptoms above.

Parent's name: _____ Address: _____ City: _____
 Date: _____ Signature of parent/guardian: _____

For Physicians Use Only

Vitals

Blood Pressure: _____ Pulse: _____

Orthopedic Exam/Normal Comments:

- Cervical Flexibility: _____
- Back Flexibility: _____
- Elbow: _____ Wrist: _____
- Hand/Fingers: _____
- Hip ROM: _____
- Knee: _____
- Ankle/Feet: _____
- Recommendations: _____
- _____
- _____
- _____

Neurological Exam: _____

Medical Exam/Normal Comments

- Eyes/Ears/Nose/Throat: _____
- Mouth: _____
- Neck: _____
- Lungs: _____
- Heart: _____
- Abdomen: _____
- Skin: _____

_____ No findings that would exclude routine participation in the sport(s) listed.
 _____ This athlete needs the following evaluations/treatments prior to participations in practice/play. _____

Physician Signature: _____
 Date: _____