



All 4 The Kids Sports

Empowering Youth Through Sports & Education

P.O. Box 334 ~ Lorain, Ohio 44052

Name _____ Sex _____ Age _____ Date of Birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
 Personal Physician _____
 In case of emergency, contact: Name _____ Relationship _____
 Phone (H) _____ (W) _____ (Cell) _____ (Cell) _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
 2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Yes No
 4. Do you have allergies to medicines, pollens, foods, or stinging insects? Yes No
 5. Do you think you are in good health? Yes No
 6. Have you ever passed out or nearly passed out DURING exercise? Yes No
 7. Have you ever passed out or nearly passed out AFTER exercise? Yes No
 8. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No
 9. Does your heart race or skip beats during exercise? Yes No
 10. Has a doctor ever told you that you have (check all that apply):
 High Blood Pressure A heart murmur
 High Cholesterol A heart infection
 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Yes No
 12. Has anyone in your family died for no apparent reason? Yes No
 13. Does anyone in your family have a heart problem? Yes No
 14. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
 15. Does anyone in your family have Marfan syndrome? Yes No
 16. Have you ever spent the night in a hospital? Yes No
 17. Have you ever had surgery? Yes No
 18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:
 19. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
 20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? 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 |
21. Have you ever had a stress fracture? Yes No
 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
 23. Do you regularly use a brace or assistive device? Yes No
 24. Has a doctor ever told you that you have asthma or allergies? Yes No

25. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
 26. Is there anyone in your family who has asthma? Yes No
 27. Have you ever used an inhaler or taken asthma medicine? Yes No
 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Yes No
 29. Have you had infectious mononucleosis (mono) within the last month? Yes No
 30. Do you have any rashes, pressure sores, or other skin problems? Yes No
 31. Have you had a herpes skin infection? Yes No
 32. Have you ever had a head injury or concussion? Yes No
 33. Have you been hit in the head and been confused or lost your memory? Yes No
 34. Have you ever had a seizure? Yes No
 35. Do you have headaches with exercise? Yes No
 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No
 37. Have you ever been unable to move your arms or legs after being hit or falling? Yes No
 38. When exercising in the heat, do you have severe muscle cramps or become ill? Yes No
 39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Yes No
 40. Have you had any problems with your eyes or vision? Yes No
 41. Do you wear glasses or contact lenses? Yes No
 42. Do you wear protective eyewear, such as goggles or a face shield? Yes No
 43. Are you happy with your weight? Yes No
 44. Are you trying to gain or lose weight? Yes No
 45. Has anyone recommended you change your weight or eating habits? Yes No
 46. Do you limit or carefully control what you eat? Yes No
 47. Do you have any concerns that you would like to discuss with a doctor? Yes No
- FEMALES ONLY**
48. Have you ever had a menstrual period? Yes No
 49. How old were you when you had your first menstrual period? _____
 50. How many periods have you had in the last 12 months? _____

Explain "Yes" Answers Here: (Attach additional sheets as needed)

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Signature: _____ Date: _____

Athlete Parent or Guardian (If athlete is under 18)

The student has family insurance Yes No; If yes, family insurance company name and policy number: _____

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
 NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 03/06

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name _____ Birth Date _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____, _____ / _____, _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues (Optional)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrb/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc

Notes: _____

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

- Cleared without restriction
 Cleared, with recommendations for further evaluation or treatment for: _____

Not cleared for: All Sports Certain sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Name of Physician: (print/type/stamp) _____ (M.D., D.O., D.C.) Date: _____

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Address: _____ Phone: _____

Signature of Physician: _____