



**envision new mexico**

The Initiative for Child Healthcare Quality

**MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS (Sports Physical)**

<http://www.envisionnm.org>

**(Cover sheet)**

**MEDICAL HISTORY – Parent/Guardian please fill out prior to examination.**

**Student Athlete Name**

**Grade:**

Last, First, M.I.

**Home Address:**

Street City State Zip

**DOB:** (Month/Day/Year)

**Age:**

**Gender:**  Male  Female

**Name of Parent/Guardian**

**Home Address:**

Street City State Zip

**Home Telephone #**

**Work Telephone #**

**Cell Phone #**

**Emergency Contact Name**

**Relationship**

**Home Telephone #**

**Work Telephone #**

**Cell Phone #**

**Home Address:**

Street City State Zip

**SPORT/ACTIVITY STUDENT WILL PARTICIPATE IN (check all that apply)**

- |                                     |  |                                   |                                      |                                     |
|-------------------------------------|--|-----------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Baseball   | <input type="checkbox"/> Cheer/Drill   | <input type="checkbox"/> Golf     | <input type="checkbox"/> Tennis      | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Cross country | <input type="checkbox"/> Soccer   | <input type="checkbox"/> Track/Field | <input type="checkbox"/> Wrestling  |
| <input type="checkbox"/> Bowling    | <input type="checkbox"/> Football      | <input type="checkbox"/> Softball | <input type="checkbox"/> Other _____ |                                     |

Please answer all health history questions on the following page PRIOR to your visit to the doctor. Please fill in the student athlete's personal information (name, gender and birth date) on each page of the form and return the entire packet to the school's athletic department.

- Cover sheet and Clearance form are returned to the school.
- Physical and Health History form stay with your medical provider.  
\*Provider, please make a copy available to family at their request\*

# MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS (Sports Physical)

## PART A - MEDICAL HISTORY – Parent/Guardian please fill out prior to examination

<b>Athlete Name</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DOB</b>
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**Explain "Yes" answers below Yes No**

1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
2. Do you have an ongoing medical condition (like asthma or diabetes)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25. Is there anyone in your family with asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
5. Have you ever become dizzy or passed out <b>DURING</b> or <b>AFTER</b> exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
6. Have you ever had chest discomfort, pain or pressure during or after exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
7. Do you get more tired than your friends do during exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29. Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
8. Has a doctor ever told you that you have: (check all that apply) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart infection <input type="checkbox"/> High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	30. Have you had a herpes infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
			31. Have you had a head injury or concussion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
9. Has a doctor ever ordered a test for your heart? (ECG, echocardiogram)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
10. Has anyone in your family ever died for no apparent reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	33. Have you ever had a seizure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
11. Does anyone in your family have a heart condition that started under the age of 50?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	34. Do you have headaches with exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
12. Has a family member or relative died of heart problems or sudden death before the age of 50?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	35. Have you ever had numbness or tingling or weakness in your arms or legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
13. Have any of relatives ever had one of the following conditions? Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's syndrome, Long QT syndrome or a significant heart arrhythmia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	36. Have you ever been unable to move your arms or legs after being hit or fallen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
			37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
14. Have you ever had racing of your heart or skipped heart beats?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
15. Have you ever spent the night in a hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
16. Have you ever had surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	41. Do you wear protective eyewear such as goggles or a face shield?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
17. 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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	42. Are you unhappy with your weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
18. Have you had any broken or fractured bones or dislocated joints? (if yes, circle affected area below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	43. Are you trying to gain or lose weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Head	Neck	Shoulder	Chest	45. Do you limit or carefully control what you eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Upper Arm	Elbow	Forearm	Hand			46. Do you have concerns that you would like to discuss with the doctor / health care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Upper Back	Lower Back	Hip	Thigh				
Knee	Calf or Shin	Ankle	Foot / Toes			47. Have you ever had a menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you ever had a stress fracture?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	48. How old were you when you had your first menstrual period?		
21. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	49. How many periods have you had in the last 12 months?		
22. Do you regularly use a brace or assistive device?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Explain "Yes" answers here:</b>		

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT:**

Student-Athlete Signature	Date	Parent or Court Appointed Legal Guardian Signature	Date

**I VERIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION**

Physician Signature	Date

## MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS (Sports Physical)

### PART B - PHYSICAL EXAMINATION - To be completed by provider

<b>Athlete Name</b>				<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>DOB</b>	
<b>Height</b>		<b>Weight:</b>		<b>Pulse:</b>		<b>BMI %ile</b> <i>(per CDC % charts)</i>	
<b>Blood Pressure:</b> <i>(Recheck if elevated)</i>		____/____	____/____	<b>Blood Pressure %ile</b> <i>(Per NIH guidelines)</i>			
<b>Vision:</b>	R 20/	L 20/	<b>Corrected:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Pupils:</b>	<input type="checkbox"/> Equal <input type="checkbox"/> Unequal
Does Athlete wear contacts?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Does Athlete require eye protection while playing?			<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS/COMMENTS
Appearance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(any physical finding of Marfan's syndrome)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eyes/Ears/Nose/Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart (auscultation should be done supine and standing- abnormal findings require referral for further evaluation)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Murmurs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulses	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs: Auscultation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Abdomen (Including liver & spleen)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Genitourinary (males only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Back	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shoulder/Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Elbow/Forearm	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wrist/Hand/Fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hip/Thigh	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Leg/Ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Foot/Toes	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**NOTES:**

**Student MAY participate in the following types of sports: (CHECK ALL THAT APPLY)**

**STUDENT CLEARED FOR ALL FORMS OF SPORTS**

Contact/Collision     Non-Contact/Strenuous     Limited Contact     Non-Contact/Non-Strenuous

**STUDENT CLEARED FOR PARTICIPATION**

**STUDENT CLEARED FOR PARTICIPATION PENDING:**

**STUDENT NOT CLEARED FOR PARTICIPATION**

Providers Name  MD  DO  NP  PA  DC

Providers Signature Date:

Name of Student's Primary Physician/Provider (for follow up, if necessary):

## MEDICAL EXAMINATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS (Sports Physical) CLEARANCE FORM

The clearance form and cover sheet goes with the athlete. The physical and history form stays with the provider performing the exam so that it becomes a part of a student's confidential medial record.

<b>Athlete Name</b>		<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>DOB</b>
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### SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

**Student MAY participate in the following types of sports: (CHECK ALL THAT APPLY)**

**STUDENT CLEARED FOR ALL FORMS OF SPORTS**

<input type="checkbox"/> Contact/Collision	<input type="checkbox"/> Non-Contact/Strenuous	<input type="checkbox"/> Limited Contact	<input type="checkbox"/> Non-Contact/Non-Strenuous
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**STUDENT CLEARED FOR PARTICIPATION**

**STUDENT CLEARED FOR PARTICIPATION PENDING:**

**STUDENT NOT CLEARED FOR PARTICIPATION**

### STUDENT ATHLETE EMERGENCY INFORMATION

<b>ALLERGIES?</b>	<b>HISTORY OF ANAPHYLAXIS?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>IMMUNIZATIONS</b> <input type="checkbox"/> Up to date	<b>Last Tetanus Immunization</b>
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**Significant Medical History Information** (Please Include any history of asthma, hypertension, previous head injury, unequal pupil size etc.)

**Student's Primary Physician/Provider** (For follow up, if necessary)

**Current Medical Conditions:**

**Current Medications**(if on asthma medication please indicate if needed prior to sports):

<b>Does Athlete wear contacts?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Does Athlete require eye protection while playing?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>Providers Name</b>	___MD___DO___NP___PA___DC
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<b>Address:</b>				
Street	City	State	Zip	TELEPHONE #

<b>Signature of Provider</b>	<b>Date:</b>
	Last updated 04/28/09