Poland Recreation Department
Pre-Participation
Athletic Health Screening & Physical Examination

***Proof of physical required every 2 years, must be current thru October 31st of playing year.**

Name ____ School: _______________
Last First M.I.
Age: _____________ DOB: _______________ Male/Female (Circle)
Grade Entering Fall 2006: __________
Parent(s)/Guardian: ____
Address: ____
Home Phone: _____________ Cell Phone: _____________ Work Phone: _________
Family Physician: ___________________________________

Medical History

Please answer the following questions. Explain Yes answers on the back page.

1. Have you ever been hospitalized?-- Yes No
2. Have you ever had surgery?-- Yes No
3. Do you have any allergies (medicine, bees, other stinging insects or food)?----------- Yes No
4. Have you ever passed out during or after exercise?--------------------------------------- Yes No
5. Have you ever had chest pain?-- Yes No
6. Have you every been dizzy during or after exercise?-------------------------------------- Yes No
7. Do you tire more quickly than your friends during exercise?--------------------------- Yes No
8. Have you ever had high blood pressure?-- Yes No
9. Have you ever been told that you have a heart murmur?------------------------------ --- Yes No
10. Have you ever had racing of your heart or skipped heart beats?----------------------- Yes No
11. Has anyone in your family died of hear problems or a sudden death before age 50?--Yes No
12. Do you have any skin problems (ie: itching, rashes, acne)?---------------------------------Yes No
13. Have you ever had a head injury?-- Yes No
14. Have you ever been knocked out or unconscious?-- Yes No
15. Have you ever had a seizure?-- Yes No
16. Have you every had a stinger, burner or pinched nerve?--------------------------------- Yes No
17. Have you ever had heat or muscle cramps?-- Yes No
18. Have you ever been dizzy or passed out in the heat?-------------------------------------- Yes No
19. Do you have trouble breathing or do you cough during of after activity?------------- Yes No
20. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards etc.)?-- Yes No
21. Have you had any problems with your eyes or vision?------------------------------------ Yes No
22. Do you wear glasses, contacts or protective eye wear?------------------------------------ Yes No
23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?--- Yes No

    Head Shoulder Thigh Neck Elbow Knee Chest Forearm Shin/ Calf
    Back Wrist Ankle Hip Hand Foot

24. Have you had any other medical problems (infectious monomucleosis, diabetes, anemia, hemophilia)?-- Yes No
25. Have you had a medical problem or injury since your last evaluation?---------------- Yes No
26. When was your last tetanus shot?_______________________________
27. When was your last measles vaccination?___________________________
28. When was your first menstrual period?____
29. When was your last menstrual periods?____
30. What was the longest time between your periods last year?____________________________

EXPLAIN YES ANSWERS:

____
____
____
____
____

The questions on the front of this form have been answered correctly and to the best of our knowledge.

Athletes signature:__________________________________Date:________________

Parent/ Guardian's signature:_________________________ Date:______________

Height __________________ Weight ___________________ BP ______/ _______

Visual acuity R_______ L _______ W/O correction or W/ correction

Exam	Normal	Not Examined	Abnormal Findings
Skin			
Heent			
Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Genitalia			
Back			
Musculoskeletal			
Femoral Pulses			
Other			

Patient cleared for: Contact Sports Non-contact sports

Patient Cleared for: Contact Sports Non-contact sports pending evaluation of:____

Denied clearance due to:____

Name of examiner:____

Physician's signature:__________________________________ Date:____________