DARIEN PUBLIC SCHOOLS
SPORTS PARTICIPATION HEALTH RECORD

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. THIS SIDE MUST BE COMPLETED BY PARENT AND STUDENT BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.

Name ____ Sex _____ Age ______ Date of Birth ____________Grade ______

Address ____Tel _________________ Personal Physician _________________

Fall Sport _________________________ Winter Sport ________________________ Spring Sport ________________________

MEDICAL HISTORY
(to be completed by parent or guardian)

1. Do you have any allergies? (food, drugs, insect stings, etc.)
   YES ____ NO ____ List: ____
2. Are you currently taking any drugs or medications including steroids or protein supplements? (daily or occasionally)
   YES ____ NO ____ List: ____
3. Are you presently being treated for any condition by a physician or other health care professional?
   YES ____ NO ____ Explain: ____
4. Have you ever been advised by a doctor not to participate in any sport?
   YES ____ NO ____ Explain: ____
5. Do you have any chronic conditions, disorders or diseases?
   YES ____ NO ____ if yes, check those applicable:

Asthma ____	Bleeding Disorders ____	Diabetes ____
Epilepsy (seizures) ____	Hepatitis (liver disease) ____	Sickle Cell Anemia ____
Hypertension (high blood pressure)____	Mononucleosis ____ year ______	Kawasaki's Disease ____

Disability (describe) ______________________________________Other _________________________________

Please check where applicable if you have or have had any of the following:

YES	NO	
____	____	Head injury, concussion, or been unconscious If yes, how many times _________
____	____	Headaches more than once a week
____	____	Lack of feeling or numbness in any part of the body
____	____	Heat exhaustion or heat stroke
____	____	Difficulty running ½ mile without stopping
____	____	Chest pain, dizziness or passing out during exercise
____	____	Coughing, wheezing or gasping for breath with exercise or cold weather
____	____	Smoke cigarettes or chew tobacco
____	____	Heart problem, murmur or arrhythmia
____	____	Family member with a heart attack under age 50
____	____	Loss or gain of more than 10 lbs. in last year
____	____	Special diet for medical reasons
____	____	Eye injury or retinal detachment
____	____	Blurred vision or vision in one eye only
____	____	Wear glasses or contact lenses

	YES	NO
Hearing loss or impairment in one or both ears	____	____
Tubes in ears or a perforated eardrum	____	____
False teeth, caps or braces	____	____
Nose bleeds for no reason	____	____
Bruising easily or taking a long time to stop bleeding when cut	____	____
Diarrhea more than once a week	____	____
Black or bloody bowel movements (stools)	____	____
Kidney disease or dark, brown or bloody urine	____	____
Less than 2 kidneys or, in males, 2 testicles	____	____
Lump(s) in armpit or groin	____	____
Rash or skin problem	____	____
Neck or spine or low back injury or pain	____	____
For female participants:		
Disabling cramps with your menstrual periods	____	____
Absent or irregular monthly periods	____	____

____ ____ Hospitalized for medical or surgical reasons? If yes, please provide the following information:

Reason	Year	Hospital
____	___________	_________________________________

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more?

Injury Area (Knee, Hamstring, Neck, Shin, etc.)	Year	Side (Right, Left)	Type (Fracture, Sprain, Swelling, Pinched Nerve, etc.)	Resolved Yes	Resolved No
________________________	______	_______	______________________________________	____	____
________________________	______	_______	______________________________________	____	____
________________________	______	_______	______________________________________	____	____
________________________	______	_______	______________________________________	____	____

STUDENT AND PARENT OR GUARDIAN: We hereby state that we have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

___________________________________	____________________	______________________________
Student Signature	Date	Parent or Guardian Signature

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MEDICAL EXAMINATION
(to be completed by Medical Doctor or his/her designee)

____ ____/____/____ has had a complete history and physical exam on ____/____/____
Student's Name Date of Birth

	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Respiratory		
Cardiovascular		
	Arrhythmia___________________ Murmur	
Abdomen		
Spine		
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner Stage) 1 2 3 4 5		

HEIGHT ______'__ __" WEIGHT ____________
BLOOD PRESSURE ________________ PULSE____________
HCT/HGB ________________________
URINALYSIS __________ protein _____ blood _____ glucose _____
VISUAL ACUITY: right ______________ left ______________
Corrected to right ______________ left ______________
HEARING ____
GROSS DENTAL ____
BODY FAT (optional) __________________________
CHOLESTEROL (optional) __________________________

LAST TETANUS BOOSTER Date ___________________
LAST MEASLES (MMR) BOOSTER Date __________________
Date HBV 1__________ HBV 2__________ HBV3 ____________
Varicella: Disease Date _________or Immunization Date________
OTHER IMMUNIZATIONS ___________________Date _________

CHRONIC DISEASE ASSESSMENT

Asthma: __mild __moderate __severe __exercise induced
Diabetes: _____ Type I _____ Type II
TB: IN HIGH RISK GROUP ___YES ___ NO
TB Test ____________ Date _________ Results _________
Seizure Disorder: ___________________
Anaphylactic Reaction: ____ food ____ insect ____ latex
Other: Please specify ________________________________

SUMMARY: ____

____

____

ORTHOPEDIC EXAM
MUSCULO-SKELETAL EVALUATION to include range of motion, strength, flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Shoulders		
Arms / Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

RECOMMENDATIONS

Weight Loss / Gain ___________________________
Strengthening ___________________________
Stretching ___________________________
Conditioning (Endurance) ___________________________

Medications ___________________________
Special Equipment ___________________________
Bracing / Taping ___________________________

I certify that on this date, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except: ____
____

______________________________, M.D. _______________ ____________________ ____________________________
Signature of Medical Doctor or designee Date Telephone Medical Doctor (Print or Stamp)