Assessment for Athletic Participation - Ss. Peter & Paul School

Student's Name: (Last)____________________(First)____________________ **School**____________________ **Grade in the Fall**__________
Address____________________________________ **Birthdate**______________ **Gender**___________ **Appt. Time**_____________
Parent/Guardian's Name______________________________ **Phone**______________
Family Physician's Name (not practice name)____

Medical History (to be completed by parent)

	Yes	No	If Yes, please explain (what, where, when).
• Diagnosed with diabetes?	___	___	
• Neurological concerns? (seizures, etc)	___	___	
• Congenital Defect?	___	___	
• Chronic illnesses/conditions?	___	___	
• History of rheumatic fever?	___	___	
• Unpaired organs i.e. one kidney?	___	___	
• History of a heart murmur?	___	___	
• Sudden death in family member?	___	___	
(if yes, during/following exercise?)	___	___	
• Chest pain during exercise?	___	___	
• Fainting or dizziness during exercise?	___	___	
• Shortness of breath associated with exercise?	___	___	
• History of asthma?	___	___	
• Past surgical operations, accidents, non-sport injuries?	___	___	
• Injuries directly related to sports?	___	___	
• Back pain during exercise?	___	___	
• Hospitalization not explained above?	___	___	
• Current medications?	___	___	
• Allergy to medicine, food or bee stings?	___	___	
• Loss of consciousness, head injury or concussion?	___	___	

• Girls only - Age of menarche ____ Date of last period ________

Signature of parent____

Findings:

Ht. ______%ile Wt. ______%ile
B/P _______ P ____ R ____
Vision R: 20/___ L: 20/___
Depth: Pass Fail

Glasses / Contacts ___ Yes ___ No
Last Eye Exam Date ___________

	Normal	Abnormal
Skin		
Heent		
Abdomen		
Respiratory		
Cardiovascular		
Genitourinary		
Skeletal/joint		
Flexibility		
Posture/Kyphoscoliosis		

Follow-up ______________________________
____

❐ Instructed on testicular self exam
❐ Cleared for participation
❐ Cleared after: ________________________
____
❐ Not cleared due to: ____________________

Signature of physician ______________________
Date_______________