

**ATHLETIC PARTICIPATION PACKET-- PHYSICAL EXAMINATION FORM**

The section below is to be completed by a physician after the attached medical history has been completed.

Students Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % of Body Fat (optional) \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_

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

| <u>MEDICAL</u>         | <u>Normal</u> | <u>ABNORMAL FINDINGS</u> | <u>Initials</u> |
|------------------------|---------------|--------------------------|-----------------|
| Appearance             |               |                          |                 |
| Eyes/ears/throat       |               |                          |                 |
| Hearing                |               |                          |                 |
| Lymph nodes            |               |                          |                 |
| Heart                  |               |                          |                 |
| Murmurs                |               |                          |                 |
| Pulses                 |               |                          |                 |
| Lungs                  |               |                          |                 |
| Abdomen                |               |                          |                 |
| Skin                   |               |                          |                 |
| <u>MUSCULOSKELETAL</u> |               |                          |                 |
| Neck                   |               |                          |                 |
| Back                   |               |                          |                 |
| Shoulder/arm           |               |                          |                 |
| Elbow/forearm          |               |                          |                 |
| Wrist/hand/fingers     |               |                          |                 |
| Hip/thigh              |               |                          |                 |
| Knee                   |               |                          |                 |
| Leg/ankle              |               |                          |                 |
| Foot/toes              |               |                          |                 |

Notes: \_\_\_\_\_  
\_\_\_\_\_

**CLEARANCE**

- Cleared without restrictions
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_
- Not cleared for:  Sports  Certain Sports: \_\_\_\_\_

Reasons and/or recommendations: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL HISTORY

Date of Exam: \_\_\_\_\_ Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**HISTORY:** Please explain "YES" answers in the space provided. Circle the questions you don't know the answers to.

1. Has a doctor ever denied or restricted your participation in sports for any reason? \_\_\_\_\_
2. Do you have an ongoing medical condition (like diabetes or asthma)? \_\_\_\_\_
3. Is there anyone in your family who has asthma? \_\_\_\_\_
4. Have you ever used an inhaler or taken asthma medication? \_\_\_\_\_
5. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? \_\_\_\_\_
6. Do you have allergies to medicines, pollens, foods or stinging insects? \_\_\_\_\_
7. Is there any reason to think you are not in good health? \_\_\_\_\_
8. Have you ever passed out or nearly passed out DURING/AFTER (circle time) exercise? \_\_\_\_\_
9. Have you ever had discomfort, pain or pressure in your chest during exercise? \_\_\_\_\_
10. Does your heart race or skip beats during exercise? \_\_\_\_\_
11. Have you ever been diagnosed with: \_\_\_\_\_  
     high blood pressure/heart murmur/high cholesterol/heart infection? \_\_\_\_\_
12. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) \_\_\_\_\_
13. Has anyone in your family died for no apparent reason? \_\_\_\_\_
14. Does anyone in your family have a heart problem? \_\_\_\_\_
15. Has any family member died of heart problems or of sudden death before age 50? \_\_\_\_\_
16. Does anyone in your family have Marfan syndrome? \_\_\_\_\_
17. Have you ever spent the night in a hospital? \_\_\_\_\_
18. Have you ever had surgery? \_\_\_\_\_
19. \_\_\_\_\_
  - a) 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 the affected area below: \_\_\_\_\_  
 Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest  
 Upper Back Lower Back Hip Thigh Knee Calf/shin Ankle Foot/toes
  - b) Have you had any broken or fractured bones or dislocated joints? 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
  - c) 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



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20. Have you ever had a stress fracture? \_\_\_\_\_

HISTORY CONTINUED: Please explain "YES" answers in the space provided. Circle the questions you don't know the answers to.

- 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? \_\_\_\_\_
22. Do you regularly use a brace or assistive device? \_\_\_\_\_
23. Do you cough, wheeze or have difficulty breathing during or after exercise? \_\_\_\_\_
24. Were you born without or are you missing any organs? \_\_\_\_\_
25. Have you had infectious mononucleosis (mono) within the last month? \_\_\_\_\_
26. Do you have any rashes, pressure sores, or other skin problems? \_\_\_\_\_
27. Have you had a herpes skin infection? \_\_\_\_\_
28. Have you ever had a head injury or concussion? \_\_\_\_\_
29. Have you been hit in the head and been concussed or lost your memory? \_\_\_\_\_
30. Have you ever had a seizure? \_\_\_\_\_
31. Do you have headaches with exercise? \_\_\_\_\_
32. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? \_\_\_\_\_
33. Have you ever been unable to move your arms or legs after being hit or falling? \_\_\_\_\_
34. When exercising in the heat, do you have severe muscle cramps or become ill? \_\_\_\_\_
35. Has a doctor told you that you or someone in your family that they have sickle trait/disease? \_\_\_\_\_
36. Have you had any problems with your eyes or vision? \_\_\_\_\_
37. Do you wear glasses or contact lenses? \_\_\_\_\_
38. Do you wear protective eyewear, such as goggles or a face shield? \_\_\_\_\_
39. Are you happy with your weight? \_\_\_\_\_
40. Are you trying to gain or lose weight? \_\_\_\_\_
41. Has anyone recommended you change your weight or eating habits? \_\_\_\_\_
42. Do you limit or carefully control what you eat? \_\_\_\_\_
43. Do you have any concerns that you would like to discuss with a doctor? \_\_\_\_\_
44. FEMALES ONLY
a) Have you ever had a menstrual period? \_\_\_\_\_
b) How old were you when you had your first menstrual period? \_\_\_\_\_
c) How many periods have you had in the last 12 months? \_\_\_\_\_

Explain "YES" answers here (be sure to include question numbers):

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Parent or Guardian

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