BROKEN BOW PUBLIC SCHOOLS PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY **REVISED 2/25/06**

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: ____Sex__________ Age________________ Date of Birth _______________
Address____Phone____________________
Grade ______________________________________ School____
Personal Physician____Phone__________________
In case of emergency, contact:
Name _______________________________ Relationship_________________ Phone (H) ______________ (W) _________________________

MEDICAL HISTORY (To be completed by student or parent) Explain "Yes" answers on an additional sheet. Circle questions you don't know the answers to. *Any Yes answer to questions 1, 2, 5, 7, 11, or 16 requires further medical evaluation which may include a physical examination*. *Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in practice or games*

	YES	NO
1. Have you had a medical illness or injury since your last check up? or sports physical?	☐	☐
2. Have you been hospitalized overnight in the past year?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or non-prescription? (over-the-counter) medication or pills or using an inhaler?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine? food, or stinging insects)?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during? exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm)?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐

If yes, how many times?________ When was the last concussion? ____________________How severe was each one? (Explain below)
____
____
____

	YES	NO
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever gotten ill from exercising in the heat?	☐	☐
9. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medication?	☐	☐
10. Have you had any problems with your eyes or vision?	☐	☐
11. Are you missing any paired organs?	☐	☐
12. Do you use any special protective or corrective equipment devices that aren't usually used for your sport or position (for example; special neck roll, foot orthodontics, retainer on your teeth or hearing aide)?	☐	☐
13. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below.

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

	YES	NO
14. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐

15. Record the dates of your ***most recent immunizations*** (shots) for:
Tetanus ____________________ MMR _____________________
Hepatitis B __________________Chickenpox _______________

	YES	NO
16. Are you under a doctor's care?	☐	☐

***Explain any "YES" answers here: A "YES" on questions 1, 2, 5, 7, 11, or 16 require further explanation.**
____
____
____
____
____

FEMALE'S ONLY-Optional
17. When was your first menstrual period? __________________
When was your most recent menstrual period? ________________
How much time do you usually have from the start of one period to the start of another? ______________________________
How many periods have you had in the last year? ____________
What was the longest time between periods in the last year? ____

Parents Please Circle any or all activities in which this student has permission to participate in:

BASEBALL	FOOTBALL	SOFTBALL	TENNIS
BASKETBALL	CHEERLEADING	TRACK & FIELD	GOLF
VOLLEYBALL	WRESTLING	CROSS COUNTRY	SOCCER
BAND	FLAG TEAM	SWIMMING	

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I authorize release to the Broken Bow Public School the information contained in this document.

Student Signature: ____ **Parent/Guardian Signature:** _________________________________**Date:** __________

If between this date and the beginning of athletic competition, any illness or injury should occur that may limit participation, I agree to notify the school authorities of such illness or injury.

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL

BROKEN BOW PUBLIC SCHOOLS PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This completed form must be kept on file at the school.

Physical Examination (to be completed by a licensed physician, physician assistant or certified advanced registered nurse practitioner)

Student's Name: ____Sex__________ Age________________ Date of Birth _______________

Height: _____________ Weight: _____________% of Body Fat (optional): __________ Pulse: _________ BP: ____/____ ____/____

Vision R 20/_____ L 20/______ Corrected: Yes No Glasses or Contacts Pupils: Equal_________ Unequal____________

Urinalysis Results: ____

	NORMAL	ABNORMAL FINDING	INITIALS *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: ____

____
____
____

☐ Not cleared for [Sport(s)]:___________________________ Reason: ____
Recommendation: ____
____
____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other heath care practitioner will not be accepted.
Name of physician/nurse practitioner/physician assistant______________________________________ Date: ___________________
Address: ____ Phone: __________________
Signature of physician/nurse practitioner/physician assistant ____

This form must be completed before a student participates in any practice, before, during or after school (both in season and out of season) games/matches. I give permission for this form and the information provided within to be shared with the Broken Bow Public Schools.