Student Name:
_____
(please print)
Birth Date:
_____
School/Group:
_____
Phone Number:
_____

Age: _____ **Gender:** _____

Students Off And Running
Physical Screening Form
2021-2022 Training
Season Physical Deadline:
12/10/21

Parent/Guardian must complete all the information down to **the black line and sign** below before student is examined.

I, (print name) _____, give my consent on behalf of my son/daughter, or the minor for whom I am legal guardian, to participate in and receive a physical screening exam. This exam may include an unclothed exam by a licensed health provider as well as urine, vision, & blood pressure screening. I understand that this exam is intended for the purpose of screening for participation in Students Off And Running and does not take the place of a physical exam provided by the student's primary health provider. I also consent to the release of information by the screening institution to the administrative care of Student's Off And Running.
Parent/Guardian Signature: _____ **Date:** _____

Medical History: 'Yes' answers to the following questions must be answered in detail and include date(s). Use reverse side if necessary. Parent/Guardian **must** answer all questions.

1. Have you ever sustained an injury, which prevented you from playing sports for more than one day? ____Yes ____No

2. Have you had any of the following injuries? (check all that apply)
___Skull fracture ___Brain surgery ___Concussion ___Knocked out ___Ligament Sprain/Strain ___Neck pain/Injury
___Broken bone ___Back pain ___Back injury ___Fainting ___Tender knee cap/Shin ___Arm/Finger numbness
___Numb leg/Toe ___Heat stroke ___Exhaustion ___Knee locking ___Joint dislocation ___Muscle pull/Locking
___Deep Bruise ___Sprains/Strains ___Other:_____

3. Do you have a history of and/or take medication (specify) for any medical problem such as: (check all that apply)
___Chest pain when exercising, ___Asthma, ___Allergy, ___Wheezing, ___Short of breath, ___Heart murmur, ___Palpitation, ___Rheumatic fever, ___High blood pressure, ___Diabetes,
___Fainting, ___Seizure, ___Yellow jaundice, ___Hepatitis, ___Severe Flu/Cold, ___Mononucleosis, ___Weakness, ___Anemia, ___Bruise easily, ___Bleeding, ___Sickle Cell, ___Loss of eyesight, ___Hearing, ___Testicle bruise, ___Kidney, ___Hernia, ___Rupture, ___Skin disease, ___Boils, ___Rash, or Other: _____

4. Are you allergic to any medication such as (circle) Penicillin, Iodine, Novacaine, or other medications? _____

5. Any family history of medically unexplained or cardiac caused sudden death under age 50? ___Yes ___No

6. Any family history of Long QT Syndrome or unexplained fainting or seizures? ___Yes ___No

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For Physician Use Only -

History O.K. ( ) Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temp:_____ Resp: _____
General Appearance: ( ) well nourished and well developed
Neuro: ( ) N ( ) Ab _____ Back: ( ) N ( ) Ab _____
Head: ( ) N ( ) Ab _____ Arm abduct: ( ) N ( ) Ab _____
Eyes: ( ) N ( ) Ab _____ Arm ext. rot. ( ) N ( ) Ab _____
Ears: ( ) N ( ) Ab _____ Pro/sup wrist: ( ) N ( ) Ab _____
Neck: ( ) N ( ) Ab _____ Flex/ext. elbow: ( ) N ( ) Ab _____
Shoulder Shrug: ( ) N ( ) Ab _____ Sprd Fingers/fist: ( ) N ( ) Ab _____
Heart: ( ) N ( ) Ab _____ Patellar reflex:: ( ) N ( ) Ab _____
Lungs: ( ) N ( ) Ab _____ Achilles Refelx: ( ) N ( ) Ab _____
Abd: ( ) N ( ) Ab _____ Quads cont/relacx: ( ) N ( ) Ab _____
Hernia: ( ) N ( ) Ab_____ Females Only – Most recent menstrual period: _____

Impression:
( ) Satisfactory Screening Exam ( ) Recommend Further Evaluation: 1) Reason: _____
2) May continue to train? __Yes __No
Physician Signature: _____Physician Name (print): _____Date: _____

*****The exam must have a DATE and PHYSICIAN STAMP and SIGNATURE.*****