

**Students Off And Running
Physical Screening Form
2017-2018 Training Season
Physical Deadline: 12/8/17**

Student Name: _____

(please print)

Birth Date: _____

School/Group: _____

Phone Number: _____

Age: _____ **Gender:** _____

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

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.*****