

**PART 1: Information (to be filled out by parent or guardian ONLY)**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sports: \_\_\_\_\_  
 Sex: M / F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Parent's Name: \_\_\_\_\_  
 Parent's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_

**PART 2: Medical History (to be filled out by parent or guardian)**

- |   |                     |                               |
|---|---------------------|-------------------------------|
| 1. Have a medical problem or injury since his/her last evaluation.....                                  | Yes                 | No                            |
| Ever not been allowed to participate in sports for a medical reason.....                                | Yes                 | No                            |
| 2. Ever been hospitalized.....  | Yes                 | No                            |
| Ever had surgery.....   | Yes                 | No                            |
| Have any missing organs (eye, kidney, testicle, etc).....   | Yes                 | No                            |
| 3. Presently take any medication.....   | Yes                 | No                            |
| 4. Have any allergies to medicine or insect bites.....  | Yes                 | No                            |
| 5. Passed out during or after exercise.....   | Yes                 | No                            |
| Been dizzy or passed out during or after exercise.....  | Yes                 | No                            |
| Have chest pain during or after exercise.....   | Yes                 | No                            |
| Tire more quickly than his/her friends during exercise.....   | Yes                 | No                            |
| Have high blood pressure.....   | Yes                 | No                            |
| Been told he/she has heart murmurs.....   | Yes                 | No                            |
| Have racing of the heart or skipped heartbeat.....  | Yes                 | No                            |
| Have a family member that died of heart problems or sudden death before AGE 50.....                     | Yes                 | No                            |
| 6. Have any skin problems.....  | Yes                 | No                            |
| 7. Ever had a head or neck injury.....  | Yes                 | No                            |
| Ever been knocked out or unconscious.....   | Yes                 | No                            |
| Ever had a seizure.....   | Yes                 | No                            |
| Ever had a stinger, burner, or pinched nerve.....   | Yes                 | No                            |
| 8. Ever had heat cramps.....  | Yes                 | No                            |
| Ever been dizzy or passed out in the heat.....  | Yes                 | No                            |
| 9. Have trouble with breathing or coughing during or after activity.....                                | Yes                 | No                            |
| 10. Use any special equipment (pads, braces, neck rolls, eye guards, kidney bell, etc).....             | Yes                 | No                            |
| 11. Have any problems with vision.....  | Yes                 | No                            |
| Wear glasses or contacts.....   | Yes                 | No                            |
| 12. Ever sprained/strained, dislocated, fractured, or had repeated swelling of any bones or joints..... | Yes                 | No                            |
| 13. Have any medical problems listed below ( please check).....   | Yes                 | No                            |
| ___ High blood pressure   | ___ Rheumatic Fever | ___ Diabetes                  |
| ___ Hepatitis   | ___ Mononucleosis   | ___ Abnormal bleeding         |
| ___ Tuberculosis  | ___ Asthma          | ___ Sickle cell disease/trait |
| ___ Other (list) _____  |                     |                               |
| 14. List dates for last: Tetanus Shot _____ Measles immunization _____                                  |                     |                               |
| 15. Female athletes list dates for : First menstrual period _____ Last menstrual period _____           |                     |                               |
| Longest time between periods last year _____  |                     |                               |

**Please explain all "yes" answers above:**

\_\_\_\_\_

- |  |     |    |
|--|-----|----|
| This information on this form is current and correct to the best of my knowledge.....  | Yes | No |
| I give my permission for my child to be examined for school related activities.....  | Yes | No |
| If, in the judgement of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent, and authorize for such care as may be deemed necessary..... | Yes | No |
| I recognize the evaluation of my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work or cardiac testing will be performed.....   | Yes | No |
| I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately.....   | Yes | No |

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Student Athlete \_\_\_\_\_ Date \_\_\_\_\_

# PHYSICAL EXAMINATION

(To be filled out by the DOCTOR)

Student Name: \_\_\_\_\_

	HEIGHT	WEIGHT	BP		PULSE
	SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENT
	Heart				
	Lung				
	Other				
	Abdominal				
	Genitalia				
	Neck				
	Shoulder				
	Elbow				
	Wrist				
	Hand				
	Back				
	Knee				
	Ankle				
	Foot				
	Eye	Right 20/	Left 20/	Corrected	Yes / No

## CLEARANCE:

\_\_\_\_\_ A. Cleared

\_\_\_\_\_ B. Cleared after further evaluation/treatment

\_\_\_\_\_ C. Not Cleared for: \_\_\_\_\_ Collision    \_\_\_\_\_ Contact    \_\_\_\_\_ Non-contact

## Recommendations:

---

---

Name of MD: \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of MD: \_\_\_\_\_



**KING'S DAUGHTERS**  
**THERAPY CENTER**

**Student-Athlete Authorization and Consent Form for  
Disclosure of Protected Health Information**

I hereby authorize the King's Daughters Medical Center athletic trainers and other health care personnel to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at \_\_\_\_\_ school.

I further understand that this protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or school administrators.

**PARENT/GUARDIAN:**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_,  
(print) (print)

student-athlete, understand that my child's protected health information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA)and, if so, may not be disclosed without either parent/legal guardian authorization under HIPAA. This authorization /consent expires one year from the date it is signed.

**STUDENT-ATHLETE:**

I, \_\_\_\_\_, student-athlete, understand that my protected health  
(print)

Information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA)and, if so, may not be disclosed without my authorization under HIPAA. This authorization /consent expires one year from the date it is signed.

\*\*\*\*\*

**SIGNATURE FOR PARTICIPATION IN INTERSCHOLASTIC SPORTS**

(Print Student-Athlete's Name)

\_\_\_\_\_

\_\_\_\_\_  
Signature Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Student-Athlete

\_\_\_\_\_  
Date