

# SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

Please Print

## Medical Examination Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender: M F SS# \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

### PHYSICAL EXAM - To Be Completed By Physician

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

|   | Normal | Abnormal Findings | Initials |
|---|--------|-------------------|----------|
| 1. Eyes (vision)                            |        |                   |          |
| 2. Ears, Nose, Throat                       |        |                   |          |
| 3. Mouth & Teeth                            |        |                   |          |
| 4. Neck                                     |        |                   |          |
| 5. Cardiovascular                           |        |                   |          |
| 6. Abdomen                                  |        |                   |          |
| 7. Chest & Lungs                            |        |                   |          |
| 8. Skin                                     |        |                   |          |
| 9. Genitalia-Hernia (male)                  |        |                   |          |
| 10. Musculoskeletal:<br>ROM, strength, etc. |        |                   |          |
| • Neck                                      |        |                   |          |
| • Spine                                     |        |                   |          |
| • Shoulders                                 |        |                   |          |
| • Arms/hands                                |        |                   |          |
| • Hips                                      |        |                   |          |
| • Thighs                                    |        |                   |          |
| • Knees                                     |        |                   |          |
| • Ankles                                    |        |                   |          |
| 11. Neuromuscular                           |        |                   |          |

Your general assessment of health (limitation, referrals, etc.) \_\_\_\_\_

Notice to Parents: urinalysis and hematocrit/hemoglobin are optional. Parents should consider both test in order to provide additional medical information.

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

# SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

## *Pre-Participation Health Assessment*

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

Address \_\_\_\_\_

Person to Notify for Emergency \_\_\_\_\_

Their Telephone Number \_\_\_\_\_

Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_

*History to be completed by student and parents*

Yes No (Check One)

1. \_\_\_\_\_ Did your grandparents, parents, brothers, sisters under the age of 50 have heart problems or high blood pressure?

*Have You Ever Had Or Do You Presently Have:*

2. \_\_\_\_\_ Heart murmur, high blood pressure, extra heart beats, heart abnormality?

3. \_\_\_\_\_ The need for using medications? name: \_\_\_\_\_

4. \_\_\_\_\_ Concussion or problem "passing out"?

5. \_\_\_\_\_ Medicine allergy? name: \_\_\_\_\_

6. \_\_\_\_\_ Any illness, condition, or injury that lasted longer than a week? name: \_\_\_\_\_

7. \_\_\_\_\_ Hospitalization or surgery? Why? \_\_\_\_\_

8. \_\_\_\_\_ Dental appliance?

9. \_\_\_\_\_ Contacts or eye glasses?

10. \_\_\_\_\_ Need to stop while running around a 1/4 mile track twice?

11. \_\_\_\_\_ An illness or injury that caused you to miss a game or practice? \_\_\_\_\_

12. \_\_\_\_\_ Congenital absence or loss of function of one organ (eye, ear...)?

13. \_\_\_\_\_ Headaches (frequent)?

14. \_\_\_\_\_ Asthma?

15. \_\_\_\_\_ Convulsions (seizures)? \_\_\_\_\_ How many? \_\_\_\_\_

16. \_\_\_\_\_ Neck or Spine injury? \_\_\_\_\_

17. \_\_\_\_\_ Broken bones? \_\_\_\_\_

18. \_\_\_\_\_ Sprains or dislocations? \_\_\_\_\_

19. \_\_\_\_\_ Date of last tetanus shot? \_\_\_\_\_

20. \_\_\_\_\_ Females: Have you had a period in the last six months?

21. \_\_\_\_\_ Females: Do menstrual cramps keep you from your regular activity?

### *Parent's Permission for Son or Daughter to Participate in Athletics*

As the parent or legal guardian of \_\_\_\_\_, I give my consent for his/her participation in athletics and the evaluation for that participation. I do not hold the school responsible in any way. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor, I understand that every effort will be made to contact me prior to treatment. I certify that the medical history is accurate to the best of my knowledge.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_