SCREENING FOR PARTICIPATION IN SPORTS

PART 1 - TO BE COMPLETED BY PARENT/GUARDIAN

Name: _____	Sex: _____	Age: _____
DOB: _____	Social Security #: _____	Grade: _____
Sport(s) Played: _____	Family MD: _____	
Address: _____	Telephone: _____	
Parent / Guardian Name: _____	Signature: _____	

HEALTH HISTORY (If Yes, please explain):

Question	No	Yes	Explanation
Does your child have allergies?			
Is your child on any medications (include non-prescriptions)?			
Has your child ever become dizzy or passed out during/after exercise?			
Any past history of chest pain?			
…high blood pressure?			
…heart murmur?			
…head injury or knocked out or unconscious?			
Does your child have trouble breathing or cough during/after activity?			
Does your child use any special equipment (e.g. pads, braces, neck rolls, mouth guards, eye guards, etc.)?			
Has your child ever had a sprained/strained, dislocated, fractured, broken or repeated swelling of any bones or joints?			
Has anyone in your family under the age of 50 had sudden cardiac death?			
When was your child's last tetanus shot?			

PART 2 - TO BE COMPLETED BY RN AND PROVIDER

Today's Date: _____ /_____ /_____			
Height: _____	Weight: _____	BP: _____ / _____	Pulse: _____
Vision: _____		Corrected? _____	
R 20 / _____	L 20 / _____	☐ Yes ☐ No	Nurse Signature: _____

PROVIDER'S EXAMINATION:

Areas Being Examined	Normal	Abnormal Findings
Pupils		
Ears		
Pulses		
Heart Sounds: Laying / Sitting / Standing		
Lung Sounds		
Abdominal		
Musculaskeletal		
Neck		
Shoulder		
Musculaskeletal System		
Neck		
Shoulder		
Elbow		
Wrist		
Back		
Knee		
Ankle		
Foot		
Inguinal / Testicles		
Other		

STATUS

_____ Cleared _____ Cleared after completing evaluation for: _____

_____ Not Cleared for ☐ Collision; ☐ Contact; ☐ Non-contact - Due to: _____

Recommendations: _____

_____

Provider Signature: _____ Date: _____