

St. Vrain Valley School District Student Medical History and Screening

The medical history information is helpful to physicians screening athletes so they may participate in district athletic programs safely, and it expedites the screening process. *You and your student* are REQUIRED to complete the form together and it must be presented at screening. The form, and any further clearance items specified by the form, must be on file with the school administration before your student is allowed to participate in athletics. If any problems arise before the time of this sports exam and the beginning of your sport, bring them to the attention of your primary physician. This screening is not a substitute for a normal physical exam performed by your personal physician. Your signature releases the physicians and the district from any responsibility. Screening is valid for (1) calendar year unless otherwise indicated. Physicians performing these screenings are participating on a volunteer basis and are hereby relieved of any liability for outcomes related to athletic participation by the students.

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an ongoing or chronic illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized overnight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever passed out during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been dizzy during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had chest pain during or after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been told you have a heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any current skin problems (for example, itching, rashes, sores, warts, fungus, or blisters)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a head injury or concussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have frequent or severe headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever become ill from exercising in the heat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any problems with your eyes or vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever broken or fractured any bones or dislocated any joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any other problems with pain, swelling, in muscles, tendons, bones, or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any other problems or swelling in muscles, tendons, bones, or joints? <i>If yes, check appropriate box and explain below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Hand	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
<input type="checkbox"/> Upper arm	<input type="checkbox"/> Foot	

Explain "Yes" answers here:

Name _____ Age _____ Date _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
In case of emergency, contact:
 Name _____ Phone (H) _____ (W) _____
 Relationship _____
 Personal physician _____

Notice to Parents and Student Athletes: Front Range Orthopedic Center (FROC) is under contract with St. Vrain Valley School District (SVVSD) to provide onsite personnel such as orthopedists, athletic trainers, and other medical providers at practices and games. However, it is understood that any student-athlete with a previous relationship with, or who requests to see another physician, will be under no obligation to receive care from FROC.

Blood Pressure #1 _____ #2 _____ Ht _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			

Medical Clearance:
 Cleared
 NOT cleared. Need further evaluation of _____ Date: _____
 Physician Signature: _____ Date: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

Orthopedic Clearance: Cleared
 NOT cleared. Need further evaluation of _____ Date: _____
 Physician Signature _____ Date: _____

Further Evaluation/Clearance:
 I have reviewed this participation evaluation form, and I have examined this athlete for the medical problem he or she was not cleared for. After further evaluation, the athlete is:
 Cleared Not Cleared
 Notes for further Recommendations: _____

Final Physician Name: _____ Date: _____
 Final Clearance Physician Signature: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Athlete signature _____ Parent signature _____ Date _____