INTERSCHOLASTIC SPORTS

To be completed by athlete or parent:

Last Name:		First Name:		Initial:			
Address:				*Lincolnwood, IL 60712*			
Birthdate:		Age:		Grade:		Student ID No.:	
Parent's Name:							
Address:							
Phone Number:							
Person to contact in case of emergency:				Phone Number:			
Family Doctor:				City/State:			
Phone Number:							

PAST MEDICAL HISTORY (for student listed above):

INFORMATION	YES	NO	If YES, please explain (what, where, when)
1. Taking Medication (incl. birth control pills)			
2. Ever been diagnosed with asthma?			
3. Ever been prescribed by a physician to use any asthma medication?			
4. Does student currently have a consent form to self-administer to asthma medication on file with your school?			
5. Allergic to medicine, foods, bee stings?			
6. Wears any appliances, glasses, contact lenses?			
7. History of braces, chipped teeth, bridges?			
8. Has ongoing medical problem?			
9. Had serious or significant illness in the past?			
10. Any past surgical operations, accidents, non-sports or related injuries?			
11. Any past injuries directly related to sports?			
12. Any hospitalization not explained above?			
13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one year, one testicle, etc.)?			
14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?			

INFORMATION *(continued)*	**YES**	**NO**	**If YES, please explain (what, where, when)**
1. Heart			
- Ever passed out during or after exercise?			
- Ever been dizzy during or after exercise?			
- Ever had chest pain during or after exercise?			
- Tired more quickly than your friends do during exercise?			
- Ever had racing of your heart or skipped heartbeats?			
- Ever had high blood pressure or high cholesterol?			
- Ever been told you have a heart murmur?			
- Has any family member or relative died of heart problems or of sudden death before age 50?			
- Ever had a severe viral infection (for ex. myocarditis or mononucleosis) within the last month?			
- Has a physician ever denied or restricted your participation in sports for any heart problems?			
- Has anyone in your family had a heart attack before the age of 50?			
2. Head and Nerve			
- Ever had a head injury or concussion?			
- Ever been knocked out, become unconscious, or lost your memory?			
- Ever had a seizure?			
- Frequent or severe headaches?			
- Ever had numbness or tingling in your arms, hands, legs, or feet?			
- Ever had a stinger, burner, or pinched nerve?			
3. Last tetanus shot?	Date:		
4. Last eye exam?	Date:		
5. Last menstrual period (if female)	Date:		

PERSONAL HABITS	**YES**	**NO**
Smoking/smokeless tobacco		
Alcohol/non-medical drugs: marijuana, cocaine, etc.		
Steroids		
Eating Disorders – weight loss or gain?		

REVIEW OF SYSTEMS (Please check if student has any problems with any of the following areas of the body.)		
☐ Skin	☐ Lungs	☐ Shoulders, Arms, Hands
☐ Head	☐ Heart	☐ Hips, Legs, Feet
☐ Eyes	☐ Abdomen	☐ Muscles – strength, feeling
☐ Ears	☐ Back	☐ Neck
☐ Nose	☐ Mental Emotional Fatigue	☐ Nutrition, Weight Control
☐ Mouth/Throat	☐ Urination, Bowel Control (incl. menstrual for female)	
☐ Other: What?		

I certify that the above information is correct to the best of my knowledge.

Parent/Guardian Signature

Student Signature

Both Student and Parent/Guardian Signatures are Mandatory

SPORTS PHYSICAL — EXAMINATION

To be completed by Physician – Page 1 of 2

Last Name:		First Name:				Initial:	
Address:							
Phone Number:		Grade:		Allergies/Asthma:			
Height:		Weight:		Blood Pressure:			
Pulse recorded:	Resting:		15 hops:		After 2 minutes:		
Visual Acuity:		Eyes (R) 20/		w/o glasses		Eyes (L) 20/		w/o glasses	

OTHER TESTING:	**NORMAL**	**ABNORMAL FINDINGS**
1. General		
2. Skin		
3. HEENT		
4. Teeth (Dental Exam)		
5. Neck		
6. Lungs		
7. Heart (Sit and Stand)		
8. Abdomen		
9. Genitalia		
10. Musculoskeletal		
- Neck		
- Shoulder/Arm		
- Elbow/Forearm		
- Wrist/Hand		
- Back		
- Hip/Thigh		
- Knee		
- Shin/Calf		
- Ankle/Leg		
- Foot		
11. Peripheral Pulses		
12. Neurologic		
13. Mental Status		
14. Marfan Screen		

Other Tests: (optional)			
Auditory:		U/V:	
Chest X-Ray:		% Body Fat:	
Drug Screen:		Tanner Stage:	
Hgb/Hct:		SMAC	

Comments or Notes:

On the basis of the examination of this day, I approve this child's participation in interscholastic sports for one year:

☐ YES	☐ NO	☐ LIMITED:	
Examination Date:			
Physician's Printed Name Or Office Stamp:			
Physician's Telephone Number:			
Physician's Signature:			