Student's Name_____ Gr._____ Student ID #_____

ATHLETIC Medical Exam Screening

General Examination to be completed by the examining PHYSICIAN

	Normal	Abnormal (describe)
Eyes, Ears, Nose, Throat:		
Skin:		
Lungs:		
Heart:		
Abdomen:		

Pulse _____
Blood Pressure _____
Height _____
Weight _____
Visual Acuity R: _____
L: _____

Suggested Musculoskeletal Exam

Neck

Motion/Strength	
Flexion	___ ___
Extension	___ ___
Rotation	___ ___
Lateral Flexion Right	___ ___
Lateral Flexion Left	___ ___

Shoulder

MOTION/STRENGTH	
Forward Flexion	___ ___
Abduction	___ ___
Extension	___ ___
Internal Rotation	___ ___
External Rotation	___ ___
Horizontal Adduction	___ ___
STABILITY	___ ___
A/C JOINT	___ ___

Elbow

MOTIONS/STRENGTH	
Biceps Flexion	___ ___
Triceps Extension	___ ___
Supination	___ ___
Pronation	___ ___

	NL	AB	Describe Abnormal
Knee Joint			
Effusion	___	___	_____
Tenderness	___	___	_____
Quadriceps			
Size	___	___	_____
Defects	___	___	_____
Patella			
Tenderness	___	___	_____
Crepitus	___	___	_____
Abnormal Tracking	___	___	_____
Subluxable	___	___	_____
Patellar Tendon	___	___	_____
Tibial Tubercle	___	___	_____
Ligaments	___	___	_____
Medical Collateral	___	___	_____
Lateral Collateral	___	___	_____
Anterior Cruciate	___	___	_____
Posterior Cruciate	___	___	_____
Cartilage Testing	___	___	_____
Strength	___	___	_____
Hip Flexors	___	___	_____
Hamstrings	___	___	_____

General Flexibility

Hamstrings	___ ___
Lumbar Spine	___ ___
Adductors	___ ___
Achilles	___ ___
Wrist/Hand	___ ___

Ankle

Motion/Strength	
Plantar Flexion	___ ___
Dorsiflexion	___ ___
Inversion	___ ___
Eversion	___ ___
Spine/Scoliosis	___ ___

Recommendations:

_____ **UNLIMITED PARTICIPATION**
_____ Clearance withheld pending further evaluation (comment below)
_____ Participation limited to specific cheer/spirit components (comment below)
_____ NO cheer/spirit participation (comment below)

Comments: _____

Physician Signature_____ Date_____

so: Revised 6.3.2016

DOCTOR STAMP REQUIRED

LIST ALL Sports you are interested in trying out for this year:

Office Use Only
AP Form Rec'd by ____

1._____ 2._____ 3._____

Pre-Participation Medical History to be completed by PARENT

Name: _____ Age: ____ DOB _____ Grade ___ Student ID #_____

Address: _____ City: _____ Zip: _____

Parent/Guardian home phone _____ Father work #_____ Mother work #_____

Parent/Guardian Email _____

Doctor's Name _____ Phone # _____

Doctor's Address _____

HEALTH HISTORY (MUST BE COMPLETED PRIOR TO THE EXAMINATION)

YES OR NO – HAS THE STUDENT HAD ANY:

1. ____ ____ Chronic or recurrent illness?
2. ____ ____ Illness lasting over 1 week?
3. ____ ____ Hospitalization?
4. ____ ____ Missing organs?
6. ____ ____ Allergies (medications, food)?
7. ____ ____ Problems with heart/blood pressure?
8. ____ ____ Chest pain/severe shortness of breath with exercise?
9. ____ ____ Dizziness or fainting with exercise?
10. ____ ___ Fainting, bad headaches or convulsions?
11. ____ ____ Concussion or loss of consciousness?
12. ____ ____ Heat exhaustion, heatstroke, or other problems with heat?

YES OR NO – IS THERE ANY HISTORY OF:

13. ____ ____ Injuries requiring physical treatment?
14. ____ ____ Neck or back injury?
15. ____ ____ Knee injury?
17. ____ ____ Ankle injury?
18. ____ ____ Other serious joint injury?
19. ____ ____ Broken bones (fractures)?

YES OR NO – FURTHER HISTORY:

20. ____ ____ Is there any reason why this student should not participate in sports?
21. ____ ____ Has any family member died suddenly at less than 40 years of age? Of causes other than an accident?
22. ____ ____ Has any family member had a heart attack at less than 55 years of age? Of what age?

YES OR NO – DOES THIS STDENT:

23. ____ ____ Wear eyeglasses or contact lenses?
24. ____ ____ Wear dental bridges, braces, retainers or plates?
25. ____ ____ Take any medications? Please list. _____

Date of last known tetanus shot: _____

Use this space to explain any yes answers to the above questions:

_____

_____

_____

_____

_____

Parent Signature _____ Date _____

so:Revised 6.3.2016