

# Medical History Information Sheet

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M.I. \_\_\_\_\_

SEX: MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sports: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_ SSN: \_\_\_\_\_

		Yes	No
Have you had a medical illness or injury since your last check up or sports physical?			
Have you had surgery in the past 5 years? Explain _____			
<b>Are you currently taking any medications?</b>			
<b>List Medications:</b> _____			
Are you currently taking any supplements?			
List supplements: _____			
Are you allergic to any medications or foods?			
List allergies: _____			
Are you allergic to bee stings?			
Do you carry an epi-pen?			
Have you ever passed out during or after exercise?			
Have you ever had chest pains during or after exercise?			
Have you or a family member had high blood pressure or high cholesterol?			
Have you ever been told you have a heart murmur or heart condition?			
Explain _____			
Do you wear glasses, contacts, or other protective eyewear?			
Do you have any hearing deficits?			
Do you use any special protective equipment that isn't usually used for your sport?			
Have you ever been treated for MRSA or other skin infection?			
Have you ever had a head injury or concussion?			
How many? _____ Date of most recent _____			
Have you ever been knocked out, become unconscious or lost your memory?			
Do you have frequent or severe headaches/migraines?			
Have you ever had a neck injury?			
Have you ever had numbness or tingling in your arms, hands, legs or feet?			
Have you ever had a stinger, burner or pinched nerve?			

**Have you had or do you currently have any of the following: please circle**

Mononucleosis    Pneumonia    Diabetes    Anemia    Epilepsy    Heat Stroke    Hernia  
 Kidney problems    Sickle Cell Trait    Asthma

**Have you had any problems with any of following? Please circle and explain.**

Back    Neck    Chest    Shoulder    Elbow    Wrist/Hand    Hip/Thigh    Knee    Ankle/Foot

Explain \_\_\_\_\_

Has a physician ever denied or restricted your participation in sports for any reason?    YES    NO

Explain \_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Medical Records Release:** I hereby give Wicomico County Board of Education Permission to obtain medical records pertaining to any injury or condition incurred while participating in high school athletics. I understand an attempt will be made to inform me of the necessity of obtaining medical records

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## WICOMICO COUNTY PUBLIC SCHOOLS PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY A BOARD CERTIFIED PHYSICIAN, PHYSICIANS ASSISTANT OR NURSE PRACTITIONER

Date of Examination \_\_\_/\_\_\_/\_\_\_

Student's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Vision R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected Y N Corrected Lenses \_\_\_\_\_ Pupils \_\_\_\_\_

### PHYSICAL REVIEW

Head & Scalp _____	Genitalia _____
Ears _____	Hernia _____
Nose & Sinus _____	Paired & Functioning Organs _____
Throat, Tonsils, Adenoids _____	Musculoskeletal _____
Thyroid _____	Injuries or Defects _____
Teeth & Gums _____	Spine: Posture _____
Chest/Lungs _____	Shoulders _____
Respirations _____	Lower Arm, Hand & Fingers _____
Breast & Nodes _____	Torso: Posture _____
Cardiovascular _____	Lower Body: Knees, Ankles & Feet _____
Heart Rate & Rhythm _____	Skin _____
Murmurs _____	Central Nervous System _____
Other _____	Pupil Response _____
Abdomen _____	Reflexes _____
Scars, Tenderness or Nausea _____	Coordination _____
Buttocks _____	Immunizations _____
Hemorrhoids _____	Tetanus _____ Date _____
Pilonidal Cyst _____	Pertinent History _____
Recommendations for Lifestyle Modification (i.e., Weight Loss) _____	_____
_____	General Summary of Physical Examination _____
_____	_____

**CLEARANCE: THIS SECTION MUST BE COMPLETED, SIGNED AND STAMPED BY THE ATTENDING PRACTITIONER**

- A. Cleared for Full Activity in ALL Sport Competition YES \_\_\_\_\_ NO \_\_\_\_\_
- B. Cleared After Completing Evaluation/Rehabilitation for \_\_\_\_\_
- C. CLEARED FOR: YES \_\_\_\_\_ NO \_\_\_\_\_
- Collision (Football, Lacrosse, Rugby)
  - YES \_\_\_\_\_ NO \_\_\_\_\_ Contact (Basketball, Baseball, Softball, Hockey, Soccer)
  - YES \_\_\_\_\_ NO \_\_\_\_\_ Noncontact (Track, Cross Country, Swimming, Golf)

Due to \_\_\_\_\_

Recommendations:

\_\_\_\_\_

Name of Practitioner (Print or Stamp) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Signature of Practitioner \_\_\_\_\_

\_\_\_\_\_