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_____		
Are you currently taking any medications?		
List Medications:_____		
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 Spinal Fusion Joint Dislocation Cartilage Injury Osgood-Schlatter's

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_____

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 _____
Ears _____
Nose & Sinus _____
Throat, Tonsils, Adenoids _____
Thyroid _____
Teeth & Gums _____
Chest/Lungs _____
Respirations _____
Breast & Nodes _____
Cardiovascular _____
Heart Rate & Rhythm _____
Murmurs _____
Other _____
Abdomen _____
Scars, Tenderness or Nausea _____
Buttocks _____
Hemorrhoids _____
Pilonidal Cyst _____
Recommendations for Lifestyle Modification
(i.e., Weight Loss) _____
_____
_____

Genitalia _____
Hernia _____
Paired & Functioning Organs _____
Musculoskeletal _____
Injuries or Defects _____
Spine: Posture _____
Shoulders _____
Lower Arm, Hand & Fingers _____
Torso: Posture _____
Lower Body: Knees, Ankles & Feet _____
Skin _____
Central Nervous System _____
Pupil Response _____
Reflexes _____
Coordination _____
Immunizations _____
Tetanus _____ Date _____
Pertinent History _____
_____
_____
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 County, Swimming, Golf)

Due to _____

Recommendations:

_____
_____

Name of Practitioner (Print or Stamp) _____ Date _____

Address _____ Telephone _____

Signature of Practitioner _____

_____