TRABUCO HILLS HIGH SCHOOL
SPORTS SCREENING ASSESSMENT

STUDENT'S NAME (PRINT):_____

DATE OF BIRTH_____ **SEX: M F** **GRADE:**_____

ADDRESS:_____

CITY:_____ **STATE:** _____ **ZIP:**_____

PHONE:_____

WEIGHT:_____ **HEIGHT:**_____

BLOOD PRESSURE:_____/_____ **PULSE:**_____**RESP:**_____

CIRCLE APPROPRIATE FINDINGS:

LUNGS: **CLEAR WHEEZING RALES OTHER**_____**PEAK FLOW**_____

CARDIAC: **RRRsM: MURMURS**_____/6: **ARRTHYMIAS** ***OTHER***_____

ABDOMEN: **NORMAL** (SOFT, BOWEL SOUNDS NL, NO MASSES) **OTHER**:_____

MUSCULOSKELETAL: **CHECK ASYMMETRIC ROM, MUSCLE IMBLALANCE, JOINT LAXITY, DEFORMITY, PAIN/SWELLING**

CIRCLE ANY JOINT WITH ABNORMAL FINDINGS AND ELABORATE:

NECK_____

SHOULDER _____

ELBOW_____

WRIST_____

HAND _____

BACK _____

HIPS _____

KNEES_____

ANKLES _____

FEET_____

EVALUATION (CIRCLE ONE)

1. **UNLIMITED ATHLETIC PARTICIPATION**
2. **MAY PARTICIPATE PENDING FURTHER EVALUATION**
   Recommendation for further W/U _____
   Referral to: _____
3. **LIMITED ATHLETIC PARTICIPATION**
   Orthopedic limitations _____
4. **ATHLETIC PARTICIPATION DENIED**
   Reasons _____

SIGNATURE OF EXAMINING/EVALUATING PHYSICIAN

_____

DATE: (Mandatory) _____

SPORTS SCREENING HEALTH QUESTIONNAIRE

STUDENT'S NAME _____

EMERGENCY CONTACT PERSON _____

RELATIONSHIP _____**PHONE ( )**_____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____**PHONE ( )**_____

DATE OF LAST VISIT/PHYSICAL_____**MEDICAL HISTORY: It is important a parent or legal guardian fill out this form completely and accurately. It is an important part of providing health care to your child, and allows the physicians focus on important areas specific to your child. Please circle all appropriate answers.**

ALLERGIES? Y/N DRUGS: Penicillin Sulfa Other _____
ENVIRONMENTAL: Bee stings Pollen Dust Other_____
What happens during the allergic reaction?_____
Current Prescription medications?_____
Reason for medication_____
Bone, joint, tendon or ligament injuries requiring medical attention? Y/N
Explanation_____
Neck or back injuries/problems? Y/N
Explanation_____
Any previous surgery? Y/N
Explanation_____
Any previous hospitalizations? Y/N
Explanation_____
Any history of loss of consciousness? Y/N
If "Yes", was the athlete: knocked out fainted?
Any history of seizures? Y/N
Explanation_____
Wear glasses Contacts? **Y/N**
Any history of asthma? Y/N
If **"Yes"** is an inhaler required? **Y/N**
Has your child ever had any PE class limitations? Y/N
Explanation_____
Has student missed any of his/her immunizations? Y/N
Any uncorrected visual condition that may impair sports participation? **Y/N**
Does student have any medical problems listed below? **Y/N**

(Circle all appropriate answers)

Loss of an organ (i.e. kidney, spleen, eye, etc)
Bleeding problems (Anemia Sickle cell, hemophilia, etc)
Respiratory problems (i.e. Shortness of breath, asthma, tuberculosis, collapsed lungs, etc.)
Cardiac problems (i.e. Murmur, etc.)
Psychiatric problems requiring medical treatment
Leukemia
Menstrual problems

Any family history of: **(Circle all appropriate answers)**
Diabetes requiring insulin Bleeding problems
Heart problems Other_____

Is there any other medical condition that you know of that should be brought to the attention of the physicians or any reason why the athlete should be limited or withheld from athletic participation? Y/N
Explanation_____

I hereby certify that the above information is true and correct.

Parent Signature_____**Date**_____