Sports Evaluation Form
Lake Orion Baptist School

ATHLETE'S NAME: _____ **Birth Date:** _____/_____/_____ **Grade:**_____
Last First

Sex: M F **Sports:**_____

Address: _____
Street City Zip

Home Phone: _____

Father's Name:_____ **Work Phone:** _____ **Cell Phone:** _____

Mother's Name: _____ **Work Phone:** _____ **Cell Phone:** _____

Family Physician: _____ **Office Phone:** _____

Medical History
(to be completed by athlete and parent)

Explain "yes" answers below.

Nervous System:
1. Have you ever had a head injury?_____ ☐ Yes ☐ No
2. Have you ever been knocked unconscious?_____ ☐ Yes ☐ No
3. Have you ever had a seizure?_____ ☐ Yes ☐ No
4. Have you ever had a stinger, burner, or pinched nerve?_____ ☐ Yes ☐ No
5. Have you ever had any problem with your eyes or vision? _____ ☐ Yes ☐ No
6. Have you ever worn glasses, contacts, or protective eyewear? _____ ☐ Yes ☐ No

Circulation:
1. Have you ever been dizzy or passed out during or after exercise? _____ ☐ Yes ☐ No
2. Have you ever had chest pain during or after exercise? _____ ☐ Yes ☐ No
3. Do you usually tire before your friends during exercise? _____ ☐ Yes ☐ No
4. Have you ever been told you have a heart murmur? _____ ☐ Yes ☐ No
5. Have you ever had a racing heart or has your heart skipped beats? _____ ☐ Yes ☐ No
6. Have you ever had anyone in your family die of heart problems or sudden death before age 50?_____ ☐ Yes ☐ No

Respiratory:
1. Do you have trouble breathing or cough during exercise? _____ ☐ Yes ☐ No
2. Do you have asthma? _____ ☐ Yes ☐ No

Musculoskeletal:
1. Do you frequently have heat or muscle cramps? _____ ☐ Yes ☐ No
2. Do you use any special equipment (pads, braces, neck rolls, mouth guards, etc.)? _____ ☐ Yes ☐ No
3. Have you had any injures of any bones or joints? _____ ☐ Yes ☐ No

☐ Head	☐ Chest	☐ Elbow	☐ Wrist	☐ Hip
☐ Ankle	☐ Knee	☐ Neck	☐ Back	☐ Shoulder
☐ Forearm	☐ Hand	☐ Thigh	☐ Calf	☐ Foot

4. Do you have any skin problems (itching, rashes, acne, etc.)?_____ ☐ Yes ☐ No

General:
1. Have you ever had surgery or been hospitalized? _____ ☐ Yes ☐ No
2. Have you had any other medical problems (infectious mono, high blood pressure, etc.)?_____ ☐ Yes ☐ No
3. Are you taking any medications or pills? _____ ☐ Yes ☐ No
4. Do you have any allergies (medicines, bees or other stinging insects)?_____ ☐ Yes ☐ No
5. When was your last tetanus shot? _____
6. When was your last measles immunization? _____

Females Only:
1. When was your first menstrual period? _____
2. When was your last menstrual period? _____
3. What was the longest time between your periods last year? _____

I would like to ask the doctor_____

Explain "Yes" answers: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I, as parent/guardian, also consent to the sports examination of the athlete under my care. Any abnormalities will be referred to the athlete's personal physician.

Signature of athlete_____ **Date**_____

Signature of parent/guardian_____ **Date**_____

Pre-Participation Physical Examination
(to be completed by physician)

Name of Athlete: _____ **Age:** _____ **Birth Date:** ____/____/____
Last First

Height: _____ **Weight:**_____ **BP** _____/_____ **Pulse:** _____

Vision: **R** 20/_____ **L** 20/_____ **Corrected:** Y N

			Comments
Heart	☐ Normal	☐ Abnormal	
Lung	☐ Normal	☐ Abnormal	
Ears	☐ Normal	☐ Abnormal	
Mouth	☐ Normal	☐ Abnormal	
Strength	**(Right)** ☐ Normal	☐ Abnormal	**(Left)** ☐ Normal ☐ Abnormal
Musculoskeletal	☐ Normal	☐ Abnormal	
Neck	☐ Normal	☐ Abnormal	
Shoulder	☐ Normal	☐ Abnormal	
Elbow	☐ Normal	☐ Abnormal	
Wrist	☐ Normal	☐ Abnormal	
Hand	☐ Normal	☐ Abnormal	
Back	☐ Normal	☐ Abnormal	
Hip	☐ Normal	☐ Abnormal	
Knee	☐ Normal	☐ Abnormal	
Ankle	☐ Normal	☐ Abnormal	
Foot	☐ Normal	☐ Abnormal	

Clearance: (check one)

☐ Cleared

☐ Cleared after completing evaluation / rehabilitation for: _____

☐ Not Cleared for:

- ☐ Contact / Collision (field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling)
- ☐ Limited Contact (baseball, basketball, bicycling, diving, high jump, pole vault, gymnastics, skating, skiing, softball, squash, volleyball)
- ☐ Noncontact:
  - ☐ Strenuous
  - ☐ Moderately strenuous
  - ☐ Nonstrenuous

Due to: _____

Recommendation: _____

_____

_____

_____

Signature of Examining Physician: _____ **Date:** _____