Regional School District 13 • Durham/Middlefield, CT

Grade

Sports Pre-Participation Health Examination-Pg. 1

Student's name: _____ Age: _____

Student's physician: _____

Sport to be played: _____

Medical History		Yes	No	Don't Know
1.	Do you have any chronic illness or see a physician regularly for any par ticular problem (e.g. epilepsy, diabetes, asthma, heart disease)?			
2.	Do you take any medication?			
3.	Are you allergic to any medication or to bee stings?			
4.	Do you have only one of any paired organ? (eyes, ears, kidneys, tes ticles, ovaries, etc.)			
5.	Have you ever had a concussion (i.e., gotten knocked out)?			
6.	Have you ever suffered a heat related illness (heat stroke)?			
7.	Do you have asthma (wheezing), hay fever, or coughing spells after exer cise?			
8.	Have you ever passed out during exercise or stopped exercise because of dizziness?			
9.	Has anyone in your family (parent, grandparent, sibling, aunt, or uncle) died suddenly before age 50?			
10.	Have you ever broken a bone, had to wear a cast, or had an injury to any joint or had any other serious injury?			
11.	Have you ever injured your neck or back?			
12.	Do you have anything you want to discuss with the doctor?			
13	Diet: Meals/day:			

_____

_____

_____

_____

Please give details for any questions answered "Yes" above.

I have answered and reviewed the questions above. I understand that this pre-participation examination is not a complete physical and is not designed to replace a routine health ex amination by my family physician.

Date: _____ Signature of student: _____

Date: _____ Signature of physician _____

indicating review of above:

Regional School District 13 • Durham/Middlefield, CT

Grade

Sports Pre-Participation Health Examination-Pg. 2

	Date:
Height:	
Weight:	
B/P:	
Urine/glucose: Urine/protein:	
Skin:	
ENT:	
Lungs:	
Heart:	
Abdomen:	
Hernia (males):	
Musculoskeletal —	
Knees:	
Ankles:	
Feet:	
Shoulders:	
Back:	
Estimate of strength:	
Estimate of flex ibility:	
Other: (if indicated by by history)	
Concussion history: if yes >	Yes/ No (circle one) # of concussions_____ date(s) sustained_____
Comments and limitations:	

Physician signature: _____ Date_____

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