School & Sports Qualifying Screening Evaluation

Please Complete in Ink

Student Name _____

Address: _____

City/Zip: _____ Telephone: _____

Date of Birth: _____ Age: _____ Male ____ Female ____

Grade: _____ School: _____

PLEASE COMPLETE PRIOR TO EXAMINATION

HISTORY	YES	NO
*1. Have you ever fainted?	☐	☐
Have you ever fainted during exercise?	☐	☐
Have you had chest pain during exercise?	☐	☐
*2. Has anyone in your family died suddenly?	☐	☐
Before age 35? _____ Before age 50 _____		
Cause _____		
*3. Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury?	☐	☐
If yes, how many times? _____		
*4. Have you ever had heat stroke or heat exhaustion?	☐	☐
*5. Do you wheeze or cough during or after exercise?	☐	☐
Do you have any history of asthma?	☐	☐
*6. Do you have any allergies? (Medications, bee sting, pollens, etc.) _____	☐	☐
*7. Any injuries since last exam?	☐	☐
If yes, list injuries: _____	☐	☐
*8. Do you take any medication? (include vitamins and nonprescription drugs) _____	☐	☐
*9. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
10. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
If yes, explain _____		
11. If female, when was your first menstrual period? _____		
When was your most recent menstrual period? _____		
12. Immunizations:		
Varicella #1_____ #2_____		
Dtap/Td/Tdap _____		
Measles, Mumps, German Measles (MMR) (1) _____ (2) _____		
Hepatitis B (1) _____ (2) _____ (3) _____		

*13. Circle any of the following you have had:

Abnormal bleeding/bruising	Anemia
Broken bones/stress fracture	Diabetes
Dislocation (shoulder, etc.)	Hearing Impairment
Heart murmur/palpitations	Hepatitis/jaundice
High blood pressure	Loss of eye sight
Rheumatic fever	Scoliosis (curvature of spine)
Seizures	Sickle-cell disease
Single organs (kidney, eye, etc.)	Undescended testicle

Other _____

☐ I have had none of the above problems.

14. Do you use seat belts on a regular basis	☐	☐
15. Do you use tobacco or alcohol	☐	☐
16. Are there any concerns you would like to discuss? (Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steriods, other)	☐	☐

* Must be answered for participation in athletics

Additional Comments: _____

_____

Student's Signature _____ Date _____

School/Clinic: **York Medical Clinic, P.C.**
Address: **2114 N Lincoln Ave. Ste A**
York, Nebraska 68467
Telephone: **(402) 362-5555** Revised 8/11

EXAMINATION

*Ht _____ Wt _____ BP _____/_____ Pulse _____

Vision R _____ L _____ Corrected Y N

Hearing

kHz	0.25	0.5	1	2	3	4	6	8
R								
L								

*MEDICAL EXAM

(cross out if omitted)	Normal	Abnormal	Comments
HEENT			
Eyes	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Throat	_____	_____	_____
Dental	_____	_____	_____
Thyroid	_____	_____	_____
Nodes	_____	_____	_____
Lungs	_____	_____	_____
Heart/Murmurs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (males)	_____	_____	_____
Hernia	_____	_____	_____
Skin	_____	_____	_____
Neck	_____	_____	_____
Upper Extremities	_____	_____	_____
Back/Spine	_____	_____	_____
Lower Extremities	_____	_____	_____
Neuro.	_____	_____	_____

Labs (If required)

UA: _____

Hgb: _____

Certification for Participation in Physical Education/Athletic Activities

I herewith certify that the student named above has been evaluated as indicated by the above record to be physically fit to participate in physical education activities and/or interscholastic athletics, except as noted below. Any exceptions or required modifications should be re-evaluated annually or as specified.

Modifications or exceptions: _____

_____

☐ Deferred pending further evaluation for _____

☐ A copy of this form should go with this individual to all sporting activities.

Required medication: _____

Provider Signature: _____ **Date:** _____

I do not know of any existing physical condition or additional health reasons that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities.

I hereby authorize release to the school nurse of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Signature _____ Date _____

(Parent or Legal Guardian)

School & Sports Qualifying Screening Evaluation

Please Complete in Ink

☐ School District – Permission to Participate

Name: _____ Birth Date: _____ Phone: _____

Parent's/Guardian's Name: _____ School: _____

STUDENT PARTICIPATION AND PARENTAL APPROVAL FORM

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not to the best of my knowledge violated any of the eligibility rules and regulations of the Nebraska School Activities Association (NSAA). I will adhere to the rules and regulations set forth by the Coaching Staff and the NSAA. Furthermore, I understand that I will be held responsible for athletic equipment checked out to me and will be ineligible for athletic participation during the season in progress if found with stolen equipment. I recognize that it is a privilege to compete in athletics and will strive to earn respect for myself, school and community. I fully understand that the school has primary training rules that apply to all athletic programs and I agree to abide by them.

PARENT'S/GUARDIAN'S PERMISSION

I hereby give my consent for the above named student to: (1) represent his/her school in organized athletic activities, except those determined to be inappropriate on the basis of a physical examination, realizing that such activity involves the potential for injury which can occur in all sports. I/We understand that even with the best coaching, the right protective equipment and abiding by the rules of the sport, injuries are still a possibility, (2) Go with any school team of which he/she is a member on any local or out of town trips. I give permission for the school to obtain, through a physician of it's own choice, any emergency medical care that my be needed for the student because of the athletic event or travel. I/We agree not to hold the school or anyone acting in its behalf responsible for an injury occurring to the above named student in the course of the activity or travel.

WARNING

The purpose of the warning is to bring to your attention that there are dangers associated with athletic participation. Participation in any athletic activity may involve injury of some type. The severity of such injury can range from minor injuries (cuts, scrapes, bruises, strains and sprains) to more serious injuries to bones, joints, ligaments, tendons, muscles or internal organs, to catastrophic injuries to the head, neck, and spinal cord. These injuries can result in permanent disability, paralysis or death.

I/We have read and understand the warning and the rules of eligibility as established by this school and know the purpose and content of this information.

_____	_____	_____
Signature of Parent or Guardian	Date	Signature of Student
_____	_____	_____
Address	City	Zip