



Health – School/Sports Screening Evaluation

Students in Grades 7th through 12th

Student's Name _____
 Address _____
 City/Zip _____
 Phone _____
 Birth Date _____ Age _____ Male ___ Female ___
 Grade _____ School: Lincoln Christian School

PLEASE COMPLETE PRIOR TO EXAMINATION

HISTORY **YES** **NO**

* Have you ever fainted?
 Have you ever fainted during exercise?
 Have you had chest pain during exercise?
 * Has anyone in your family died suddenly?
 Before age 35? _____ Before age 50 _____
 Cause _____
 * Have you ever had heat stroke or heat exhaustion?
 * Do you wheeze or cough during or after exercise?
 Do you have any history of asthma?
 * Do you have any allergies? (medications, bee sting, pollens, etc.)
 * Any injuries since last exam?
 If yes, list injuries _____
 * Do you take any medication? (include vitamins and nonprescription drugs)
 * Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
 Have you ever been hospitalized?
 Have you ever had surgery?
 If yes, explain _____
 If female, when was your first menstrual period? _____
 When was your most recent menstrual period? _____
 In the last year, what was your:
 Lowest weight _____ Your highest weight _____
 What do you think is your ideal weight? _____
 Immunizations: Last tetanus shot _____
 Measles, Mumps, German Measles (MMR) 1 _____ 2 _____
 Hepatitis B 1 _____ 2 _____ 3 _____

* 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	Seizures
Scoliosis (curvature of spine)	Sickle cell disease
Single organs(kidney, eye, etc.)	Undescended testicle

Other _____

I have had none of the above problems.

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

* **Must be answered for participation in athletics**

Student's Signature _____ Date _____

Clinic _____
 Address _____
 Phone _____

EXAMINATION

*Ht _____ Wt _____ BP _____ / _____ Pulse _____
 Vision R _____ L _____
 Hearing

kHz	0.25	0.5	1	2	3	4	6	8
R								
L								

***MEDICAL EXAMINATION**

(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 _____
 Neurological _____

Labs (if required)
 UA dip: Ap _____ col _____ sp gr _____ pH _____ Pr _____ sug _____ Ket _____ Bld _____
 Bil _____ Uro _____ leuk _____ nitr _____ 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 _____

Physician Signature _____ **Date** _____

I do not know of any existing physical condition or additional health reason 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