

**Athletic Screening**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Sports: \_\_\_\_\_

**Parents complete this section**

**Athlete Injury History**

- Concussion/Knocked out
- Any neck injury
- Shoulder L / R
- Back
- Hip/Thigh
- Knee: ligaments, bone, cartilage
- Shin splints
- Ankle/foot
- Muscle tear/strain
- Pinched nerve ("stingers")
- Other injuries \_\_\_\_\_
- Hernia/rupture \_\_\_\_\_
- Have you ever had surgery? If so, what kind? \_\_\_\_\_
- Have you ever been in the hospital for a health problem? If so, what kind? \_\_\_\_\_
- Has a doctor ever recommended that you not participate in sports? If so, why? \_\_\_\_\_
- Allergies: Please list \_\_\_\_\_

**Athlete Medical History**

- Serious or chronic health problems
- Heart murmur
- Chest pains
- Diabetes
- Seizures/epilepsy
- Fainted with exercise
- Kidney disease/blood in urine
- Single/missing organ (testicle, eye, kidney)
- Asthma
- Mononucleosis/enlarged spleen

\*\*\*I grant permission for this evaluation. I understand this is a limited exam and does not prevent injury or sudden death. The purpose of this form is to screen young adults who may be exhibiting symptoms of heart disease that could cause their heart to stop suddenly in an athletic event. Please question your child thoroughly about the symptoms above. \*\*\*

Parent's name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Date: \_\_\_\_\_ Signature of parent/guardian: \_\_\_\_\_

**For Physicians Use Only**

**Vitals**

Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Neurological Exam: \_\_\_\_\_

**Medical Exam/Normal Comments**

Eyes/Ears/Nose/Throat: \_\_\_\_\_  
 Mouth: \_\_\_\_\_  
 Neck: \_\_\_\_\_  
 Lungs: \_\_\_\_\_  
 Heart: \_\_\_\_\_  
 Abdomen: \_\_\_\_\_  
 Skin: \_\_\_\_\_

Orthopedic Exam/Normal Comments: Blood  
 Cervical Flexibility: \_\_\_\_\_  
 Back Flexibility: \_\_\_\_\_  
 Elbow: \_\_\_\_\_ Wrist: \_\_\_\_\_  
 Hand/Fingers: \_\_\_\_\_  
 Hip ROM: \_\_\_\_\_  
 Knee: \_\_\_\_\_  
 Ankle/Feet: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- No findings that would exclude routine participation in the sport(s) listed.
- This athlete needs the following evaluations/treatments prior to participations in practice/play \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

