St. Vrain Valley School District Student Medical History and Screening

The medical history information is helpful to physicians screening athletes so they may participate in district athletic programs safely, and it expedites the screening process. *You and your student* are REQUIRED to complete the form *together* and it must be presented at screening. The form, and any further clearance items specified by the form, must be on file with the school administration before your student is allowed to participate in athletics. If any problems arise between the time of this sports exam and the beginning of your sport, bring them to the attention of your primary physician. **This screening is not a substitute for a normal physical exam performed by your personal physician. Your signature releases the physicians and the district from any responsibility. Screening is valid for (1) calendar year unless otherwise indicated.** Physicians performing these screenings are participating on a volunteer basis and are hereby relieved of any liability for outcomes related to athletic participation by by the students.

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
Have you ever become ill from exercising in the heat?	☐	☐
Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete signature_____ Parent signature_____ Date_____

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Name_____ Age____ Date_____
Grade____ School_____ Sports(s)_____
Address_____ Phone_____
In case of emergency, contact:
Name_____
Relationship_____ Phone (H)_____ (W)_____
Personal physician_____

Notice to Parents and Student Athletes: Front Range Orthopedic Center (FROC) is under contract with St. Vrain Valley School District (SVVSD) to provide onsite personnel such as orthopedists, athletic trainers, and other medical providers at practices and games. However, it is understood that any student-athlete with a previous relationship with, or who requests to see another physician, will be under no obligation to receive care from FROC.

Blood Pressure #1_____ #2_____ Ht_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station based examination only

Clearance
☐ Cleared
☐ Cleared after completing evaluation for:_____
☐ Reason not cleared:_____
Recommendations:_____

Checkout Physician Name_____ Date_____
Checkout Physician Signature_____

Further Evaluation/Clearance:
I have reviewed this preparticipation evaluation form, and I have examined this athlete for the medical problem that he or she was not cleared for. After further evaluation, the athlete is: ☐ Cleared ☐ Not Cleared
Notes or further recommendations:_____

Final Physician Name:_____ Date:_____
Final Clearance Physician Signature:_____