ST. CHARLES CATHOLIC SCHOOL

SPORTS PARTICIPATION SCREENING RISK ASSESSMENT

STUDENT INFORMATION

Name:_____ Birth date:_____

Address:_____

Home Phone:_____ Grade:_____

MEDICAL HISTORY

1. Have you ever been hospitalized? Yes No Reason?_____
2. Have you ever had surgery? Yes No Reason?_____
3. Have you ever sustained a concussion or been knocked out? YES NO
4. Have you been treated for any of the following (circle those which apply):
   Diabetes Hernia Heart Problems Seizures Asthma High Blood Pressure
5. Have you been injured any of the following (circle those which apply):
   Neck Shoulder Hip Back Elbow Knee Jaw Wrist/Hand Ankle/Foot
6. Have you ever experienced chest pain or dizziness during exercise? YES NO
7. Has anyone in your immediate family under the age of 50 died suddenly? YES NO

Height: _____ Weight:_____

Blood Pressure:_____ Pulse:_____

	Normal	Abnormal
Flexibility/Posture:		
Upper Extremities:	_____	_____
RON Screens:		
Lower Extremities:	_____	_____

Scoliosis: NO YES

Comments:_____

ORTHOPEDIC EXAMINATION

Upper Extremities	Normal	Abnormal	Lower Extremities	Normal	Abnormal
Shoulder	_____	_____	Hip	_____	_____
Elbow	_____	_____	Knee	_____	_____
Wrist/Hand	_____	_____	Ankle	_____	_____
Spine	_____	_____	Foot	_____	_____

Comments:_____

PHYSICAL EXAMINATION

	Normal	Abnormal		Normal	Abnormal
Head & Neck	_____	_____	Cardiovascular	_____	_____
Eyes	_____	_____	Gastrointestinal	_____	_____
Ear/Nose & Throat	_____	_____	Genito-Urinary	_____	_____

Comments:_____

PHYSICAL DETERMINATION

In my opinion this student:

_____ Is cleared for sports participation
_____ Is NOT cleared for sports participation
_____ Deferred

Note: Hospital, Clinic or Doctor's Stamp REQUIRED

Physician:_____ **M.D.**

Date of Physical:_____

Comments:_____

Parent/Guardian Signature: _____ **Date:** _____