

STUDENT HEALTH REVIEW/EXAM

To be completed by parent or guardian.

Student Last Name	Student First Name	MI	Date of birth	Grade
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Address	City	Zipcode
<input style="width: 98%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Phone	Emergency Phone	Date of last physical exam
<input style="width: 98%;" type="text"/>	<input style="width: 98%;" type="text"/>	<input style="width: 98%;" type="text"/>

Are your immunizations up to date?	Last tetanus shot	Last measles shot	Last TB skin test
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or a household contact been diagnosed with COVID-19? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told that you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped beats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any skin problems (<i>itching, rashes, acne</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had a concussion? If yes, how many _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you suffer from migraines? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you use any medical assistant devices (<i>insulin pump, prosthetic, implanted device, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| _____Head _____Shoulder _____Thigh _____Neck _____Elbow _____Knee _____Chest
_____Forearm _____Shin/calf _____Back _____Wrist _____Ankle _____Hip _____Hand | | |
| 27. Have you ever had other medical problems (<i>infectious mononucleosis, diabetes, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had any medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Are you Diabetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are you Asthmatic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any allergies (<i>medicine, bees or other stinging insects</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| List all allergies: _____ | | |
| 32. When was your first menstrual period? _____ | | |
| When was your last menstrual period? _____ | | |
| What was the longest time between your periods last year? _____ | | |
| 33. Explain all "yes" answers: _____ | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH REVIEW/EXAM

To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic
This form to be sent to the school (do not send to ASAA)

Student Last Name	Student First Name	MI	Date of birth	Grade
			/ /	

EXAMINATION	SEX ASSIGNED AT BIRTH	PREFERRED PRONOUNS
Height _____ Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/> Other: _____
BP _____ / _____ (_____ / _____) Pulse _____	Vision R 20/ _____	L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of M.D., D.O. P.A., ANP, CHAP or DC (circle)	Signature	Date
		/ /
Address	Phone	