

**Students Off And Running  
Physical Screening Form  
2009-2010 Training Season  
Physical Deadline: 11/27/09**

**Student Name:** \_\_\_\_\_

(please print)

**Birth Date:** \_\_\_\_\_

**School/Group:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Parent/Guardian** must complete all the information down to **the black line and sign** below before student is examined.

I, (print name) \_\_\_\_\_, give my consent on behalf of my son/daughter, or the minor for whom I am legal guardian, to participate in and receive a physical screening exam. This exam may include an unclothed exam by a licensed health provider as well as urine, vision, & blood pressure screening. I understand that this exam is intended for the purpose of screening for participation in Students Off And Running and does not take the place of a physical exam provided by the student's primary health provider. I also consent to the release of information by the screening institution to the administrative care of Student's Off And Running.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical History:** 'Yes' answers to the following questions must be answered in detail and include date(s). Use reverse side if necessary. Parent/Guardian **must** answer all questions.

1. Have you ever sustained an injury, which prevented you from playing sports for more than one day? \_\_\_ Yes \_\_\_ No

2. Have you had any of the following injuries? (check all that apply)

\_\_\_ Skull fracture \_\_\_ Brain surgery \_\_\_ Concussion \_\_\_ Knocked out \_\_\_ Ligament Sprain/Strain \_\_\_ Neck pain/Injury  
\_\_\_ Broken bone \_\_\_ Back pain \_\_\_ Back injury \_\_\_ Fainting \_\_\_ Tender knee cap/Shin \_\_\_ Arm/Finger numbness  
\_\_\_ Numb leg/Toe \_\_\_ Heat stroke \_\_\_ Exhaustion \_\_\_ Knee locking \_\_\_ Joint dislocation \_\_\_ Muscle pull/Locking  
\_\_\_ Deep Bruise \_\_\_ Sprains/Strains \_\_\_ Other: \_\_\_\_\_

3. Do you have a history of and/or take medication (specify) for any medical problem such as: (check all that apply)

\_\_\_ Chest pain when exercising, \_\_\_ Asthma, \_\_\_ Allergy, \_\_\_ Wheezing, \_\_\_ Short of breath, \_\_\_ Heart murmur, \_\_\_ Palpitation, \_\_\_ Rheumatic fever,  
\_\_\_ High blood pressure, \_\_\_ Diabetes,  
\_\_\_ Fainting, \_\_\_ Seizure, \_\_\_ Yellow jaundice, \_\_\_ Hepatitis, \_\_\_ Severe Flu/Cold, \_\_\_ Mononucleosis, \_\_\_ Weakness, \_\_\_ Anemia, \_\_\_ Bruise easily,  
\_\_\_ Bleeding, \_\_\_ Sickle Cell, \_\_\_ Loss of eyesight, \_\_\_ Hearing, \_\_\_ Testicle bruise, \_\_\_ Kidney, \_\_\_ Hernia, \_\_\_ Rupture, \_\_\_ Skin disease, \_\_\_ Boils,  
\_\_\_ Rash, or Other: \_\_\_\_\_

4. Are you allergic to any medication such as (circle) Penicillin, Iodine, Novacaine, or other medications? \_\_\_\_\_

5. Any family history of medically unexplained or cardiac caused sudden death under age 50? \_\_\_ Yes \_\_\_ No

6. Any family history of Long QT Syndrome or unexplained fainting or seizures? \_\_\_ Yes \_\_\_ No

**For Physician Use Only -**

History O.K. ( ) Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_ Resp: \_\_\_\_\_

General Appearance: ( ) well nourished and well developed

Neuro: ( ) N ( ) Ab \_\_\_\_\_ Back: ( ) N ( ) Ab \_\_\_\_\_

Head: ( ) N ( ) Ab \_\_\_\_\_ Arm abduct: ( ) N ( ) Ab \_\_\_\_\_

Eyes: ( ) N ( ) Ab \_\_\_\_\_ Arm ext. rot. ( ) N ( ) Ab \_\_\_\_\_

Ears: ( ) N ( ) Ab \_\_\_\_\_ Pro/sup wrist: ( ) N ( ) Ab \_\_\_\_\_

Neck: ( ) N ( ) Ab \_\_\_\_\_ Flex/ext. elbow: ( ) N ( ) Ab \_\_\_\_\_

Shoulder Shrug: ( ) N ( ) Ab \_\_\_\_\_ Sprd Fingers/fist: ( ) N ( ) Ab \_\_\_\_\_

Heart: ( ) N ( ) Ab \_\_\_\_\_ Patellar reflex: ( ) N ( ) Ab \_\_\_\_\_

Lungs: ( ) N ( ) Ab \_\_\_\_\_ Achilles Refelx: ( ) N ( ) Ab \_\_\_\_\_

Abd: ( ) N ( ) Ab \_\_\_\_\_ Quads cont/relacx: ( ) N ( ) Ab \_\_\_\_\_

Hernia: ( ) N ( ) Ab \_\_\_\_\_ Females Only – Most recent menstrual period: \_\_\_\_\_

Impression:

( ) **Satisfactory Screening Exam** ( ) **Recommend Further Evaluation:** 1) Reason: \_\_\_\_\_

2) May continue to train? \_\_\_ Yes \_\_\_ No

Physician Signature: \_\_\_\_\_ Physician Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*The exam must have a DATE and PHYSICIAN STAMP and SIGNATURE.\*\*\***