Student Name: ____

(please print)

Birth Date: ____

School/Group: ____

Phone Number: ____

Age: ___________ **Gender:** ______________

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

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

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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.*****