

STUDENT HEALTH REVIEW/EXAM

To be completed by parent or guardian.

Student Last Name	Student First Name	MI	Date of birth	Grade
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		City	Zipcode	
<input type="text"/>		<input type="text"/>	<input type="text"/>	
Phone	Emergency Phone	Date of last physical exam		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Are your immunizations up to	Last tetanus shot	Last measles shot	Last TB skin test	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>	<input type="text"/>	

	YES	NO
1. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you 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, pills or supplements?	<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"/>
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand		
27. Are you Diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
28. Are you Asthmatic?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you had any medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you have any allergies (<i>medicine, bees or other stinging insects</i>)??	<input type="checkbox"/>	<input type="checkbox"/>
List all allergies: _____		
31. Have you ever had other medical problems (<i>infectious mononucleosis, etc.</i>)?	<input type="checkbox"/>	<input type="checkbox"/>
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		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
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 resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of M.D., D.O. P.A., ANP or DC (circle)

Signature

Date

Address

Phone