

Oakbrook Preparatory School Medical Examination Form for Athletic Participation

Medical Examination Form to be completed by a Licensed Physician and returned to the Athletic Department.

Student's Name: _____ Date of Examination: _____

BP: _____ Pulse: _____ Height: _____ Weight: _____

Vision: (R) _____ (L) _____ Glasses? _____ Contacts? _____

Hearing: (R) _____ (L) _____ Hearing Aid? _____

Cardiovascular Exam: _____ Normal _____ Abnormal (Comments: _____)

Murmur: _____ Yes _____ No Describe if yes: _____

Musculoskeletal Exam: Record laxity, weakness, instability, decreased ROM – if abnormal

Head/Neck	_____	Normal	_____	Abnormal
Back	_____	Normal	_____	Abnormal
Shoulder/Arm/Elbow	_____	Normal	_____	Abnormal
Wrist/Hand/Finger	_____	Normal	_____	Abnormal
Hip/Thigh	_____	Normal	_____	Abnormal
Knee	_____	Normal	_____	Abnormal
Leg/Ankle/Foot/Toe	_____	Normal	_____	Abnormal

Other comments: _____

General Exam:

ENT	_____	Normal	_____	Abnormal
Chest/Lung	_____	Normal	_____	Abnormal
Abdomen	_____	Normal	_____	Abnormal
Genitalia	_____	Normal	_____	Abnormal
Skin	_____	Normal	_____	Abnormal
Dental	_____	Normal	_____	Abnormal

Other comments: _____

Please Print:

Physician's Name _____ Phone: (____) _____

Address: _____

City, ST Zip: _____

I certify that I have examined the above student and that such examination revealed
_____ conditions / _____ no conditions
that would prevent this student from participating in scholastic sports activities.

Signature of Examining Physician: _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN FOR THE STUDENT PRIOR TO PHYSICIAN'S EXAMINATION

Student's Name _____

Fill Yes/No Boxes. Explain "Yes" answers. Circle questions you don't know the answers to completely.

			Explain "Yes"
1. Have you had a medical illness or injury since your last check up or sports physical?	Y	N	
2. Do you have an on-going chronic illness?	Y	N	
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	Y	N	
4. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	Y	N	
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	Y	N	
6. Have you ever had a rash or hives develop during or after exercise?	Y	N	
7. Have you ever passed out during or after exercise?	Y	N	
8. Have you ever been dizzy during or after exercise?	Y	N	
9. Have you ever had chest pain, chest discomfort, or unexplained shortness of breath during or after exercise?	Y	N	
10. Do you get tired more quickly than your friends do during exercise?	Y	N	
11. Have you ever had racing of your heart or skipped heartbeats?	Y	N	
12. Have you had high blood pressure or high cholesterol?	Y	N	
13. Have you ever been told you have a heart murmur?	Y	N	
14. Has any family member or relative died of heart problems or sudden death before age 50?	Y	N	
15. Has any relative younger than 50 ever had disability from heart or cardiovascular disease?	Y	N	
16. Do you have, or do you know any family member or relative with ANY heart condition (Marfans, cardiomyopathy, or arrhythmia – irregular heartbeat)	Y	N	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	Y	N	
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	Y	N	
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	Y	N	
20. Have you ever had a head injury or concussion?	Y	N	
21. Have you ever been knocked out, become unconscious, or lost your memory	Y	N	
22. Have you ever had a seizure?	Y	N	
23. Do you have frequent or severe headaches?	Y	N	
24. Have you ever had numbness or tingling in your arms, hand, legs or feet?	Y	N	
25. Have you ever had a stinger, burner, or pinched nerve?	Y	N	
26. Have you ever become ill from exercising in the heat?	Y	N	
27. Do you cough, wheeze, or have trouble breathing during or after activity?	Y	N	
28. Do you have asthma?	Y	N	
29. Do you have seasonal allergies that require medical treatment?	Y	N	
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	Y	N	
31. Have you had any problems with your eyes or vision?	Y	N	
32. Do you wear glasses, contacts, or protective eyewear?	Y	N	
33. Have you ever had a sprain, strain, or swelling after injury?	Y	N	
34. Have you ever broken or fractured any bones or dislocated any joints?	Y	N	
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	Y	N	
36. Do you want to weight more or less than you do right now?	Y	N	
37. Do you lose weight regularly to meet weight requirements for your sport?	Y	N	
38. Do you feel stressed out?	Y	N	
39. Record the dates of your mos recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____			
Explain any injury here:			

FEMALES ONLY	
40. When was your first menstrual period?	
41. When was your most recent menstrual period?	
42. How much time do you usually have from the start of one period to the start of another?	
43. How many periods have you had in the last year?	
44. What was the longest time between periods in the last year?	

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Legal Guardian Sign: _____ Date: _____