

GALLATIN GATEWAY - SCHOOL DISTRICT #35

ATHLETIC EVALUATION

Student's Name _____ Age ____ Birthdate _____ Grade ____
 Address _____ Phone _____

I. Medical History (Completed by Parent/Guardian and Student PRIOR to physical examination)

Please check Yes or No below to indicate whether your child has ever had any of the following conditions:

| No | Yes | | No | Yes | |
|----|-----|------------------------------------------------------------------------------------------------------|----|-----|---------------------------------------------------------|
| | | Head injury, concussion, loss of consciousness | | | Back injury/chronic low back pains |
| | | Dizzy spells, fainting, convulsions, seizure disorders | | | Any allergies or skin problems |
| | | Pinched nerves, vertebra, disc injury | | | Any vision problems |
| | | Any organs removed | | | Heat cramps, exhaustion, or stroke |
| | | Heart trouble or rheumatic fever or heart murmur | | | Any other surgery or major injury |
| | | High or low blood pressure | | | Pin, screw, or plate somewhere in body |
| | | Anemia, hepatitis, jaundice, or mononucleosis | | | Major illness requiring hospitalization |
| | | Hernia, testicle or menstrual problems | | | Any problems during exercise |
| | | Tendonitis, bursitis, arthritis, or gout | | | Chronic medical problem (Diabetes, asthma, etc.) |
| | | Shoulder dislocation, separation or surgery | | | Allergy to medication |
| | | Fractures or joint dislocation | | | Any medication taken regularly |
| | | Osgood-Schlatter, Shin splints, or chondromalacia | | | Do you wear contacts/glasses? |
| | | Ligament/cartilage damage to knee | | | Shortness of breath, wheezing, chronic cough |
| | | Surgery to correct a knee or ankle injury | | | Family History of sudden death age less than 50 |
| | | Any musculoskeletal injury causing a loss of activity (sprains/strains) <i>not already mentioned</i> | | | Do you currently have any incompletely healed injuries? |

Any Questions to ask the examiner _____

Signature of Individual completing Medical History: _____

Please print name: _____ **Relationship:** _____

II. Physical Examination (Completed by Health Care Provider)

Note to Health Care Provider: Please review the medical history and perform a thorough examination of the athlete. *Please note any specific concerns or conditions below.*

Student's Height _____ Weight _____ Blood Pressure _____ Last Tetanus shot date _____

| | | |
|----------------|--------|----------|
| Vision Screen | Normal | Abnormal |
| Hearing Screen | Normal | Abnormal |
| Lungs | Normal | Abnormal |

Restrictions/Recommendations and/or past medical history the coaches need to be aware of regarding the student (please address any YES areas of the medical history):

I have examined the above named student and found him/her able to participate in all sport activities

Physician's Name _____ -5- _____ Date _____ Phone _____