SCHOOL BOARD OF SEMINOLE COUNTY, FL
MIDDLE SCHOOL
SPORTS SCREENING/PHYSICAL & PARENT/STUDENT RELEASE FORM

PART 1: Student information (to be completed by student or parent)

Student's Name: _____ **Sex:** _____ **Age:** _____ **Date of Birth:** ____/____/____

Grade: ____ **Home Phone:** ( ) _____ **Work Phone:** ( ) _____ **Cell Phone:** ( ) _____

Home Address: _____, _____ **Legal Name of Parent/Guardian:** _____
City

Emergency Contact: _____ **Relationship to Student:** _____ **Home #** (____) _____ **Work #** (____) _____

Family Physician: _____ **City:** _____ **Office Phone:** (____) _____ **Previous School:** _____

PART 2: Verification of medical insurance: Insurance coverage is required for participation in athletic events. Athletes must have personal insurance coverage or school purchased insurance. School insurance covers all sports.

My child/ward is covered under a family policy, which has limits $ 25,000, or school purchased policy. Sport(s) played _____

Individual Insurance Company Name_____ Policy #_____

School Insurance Company Name_____ Policy #_____

PART 3: Medical History to be completed by student or parent. Explain "yes" answers on separate page. Please circle any questions you are unable to answer.

	Yes	No
1. Have you had a medical illness or injury since your last check or sports physical?		
2. Do you have an ongoing chronic illness?		
3. Have you ever been hospitalized overnight?		
4. Have you ever had surgery?		
5. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?		
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
7. Do you have any allergies, for example(pollen, medicine, food or stinging insects)?		
8. Have you ever had a rash or hives develop during or after exercise?		
9. Have you ever passed out during or after exercise?		
10. Have you ever been dizzy during or after exercise?		
11. Have you ever had chest pain during or after exercise?		
12. Do you get tired more quickly than your friends do during exercise?		
13. Have you ever had racing of your heart or skipped heartbeats?		
14. Have you had high blood pressure or high cholesterol?		
15. Have you ever been told you have a heart murmur?		
16. Has any family member or relative died of heart problems or sudden death before age 50?		
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the month?		
18. Has a physician ever denied or restricted your participation in sports for any heart problems.?		
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
20. Have you ever had a head injury or concussion?		
21. Have you ever been knocked out, become unconscious, or lost your memory?		
22. Have you ever had a seizure?		
23. Do you have frequent or severe headaches?		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
25. Have you ever had a stinger, burner, or pinched nerve?		
26. Have you ever become ill from exercising in the heat?		
27. Do you cough, wheeze, or have trouble breathing during or after activity?		

	Yes	No
28. Do you have asthma?		
29. Do you have seasonal allergies that require medical treatment?		
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)?		
31. Have you had any problems with your eyes or vision?		
32. Do you wear glasses, contacts, or protective eyewear?		
33. Have you ever had a sprain, strain, or swelling after injury?		
34. Have you broken or fractured any bones or dislocated any joints?		
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes, check appropriate blank and explain below.

___Head ___Elbow ___Hip ___Neck ___Ankle
___Thigh ___Back ___Wrist ___Knee
___Hand ___Shin/Calf ___Shoulder ___Finger
___Upper Arm ___Foot ___Forearm ___Chest

36. Do you want to weigh more or less than you do now?		
37. Do you lose weight regularly to meet weight requirements for your sport?		
38. Do you feel stressed out?		

39. Record the dates of your most recent immunizations (shots) for:
Tetanus:_____ Measles:_____
Hepatitis B: _____ Chickenpox:_____

Females Only (optional)

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?_____

PART 4: Physical Examination (to be completed by physician).

Student's Name: _____ Date of Birth: ____/____/____ Height: _____ Weight: _____
% Body Fat (optional): _____ Pulse: _____ Blood Pressure: ____/____ (____/____ . ____/____) Visual Acuity: Right 20/ _____ Left 20/_____ Corrected: Yes No
Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS
MUSCULOSKELETAL			
1. Neck			
2. Back			
3. Shoulder/Arm			
4. Elbow/Forearm			
5. Hand/Wrist			
6. Hip/Thigh			
7. Knee			
8. Leg/Ankle			
9. Foot			
10. Appearance			

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
11. Heart			
12. Pulses			
13. Lymph Nodes			
14. Lungs			
15. Abdomen			
16. E/E/N/T			
17. Skin			
18. Genitalia (Males only)			