

ATHLETIC FORM C
OXFORD HIGH SCHOOL SPORTS PARTICIPATION HEALTH RECORD

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. *THIS SIDE MUST BE COMPLETED BY PARENT/GUARDIAN & STUDENT BEFORE BEING BROUGHT TO THE DOCTORS OFFICE.*

Name _____ Age _____ Sex _____ School _____
 Address _____ Phone _____ Grade _____
 Sports Being Played (Please list) _____

Medical History

1. Do you have any allergies? (Drugs, food, insect bites etc.)
 No _____ Yes _____ Please list allergy and any medication required _____
2. Are you currently taking any drugs or medications including steroids or protein supplements? (Daily or occasionally)
 No _____ Yes _____ List _____
3. Are you presently being treated for any condition by a physician or other health care professional ?
 No _____ Yes _____ Explain _____
4. Have you ever been advised by a doctor not to participate in any sport?
 No _____ Yes _____ Explain _____
5. Do you have any chronic conditions, disorders or diseases?
 No _____ Yes _____ Please check those which are applicable:
 _____ Asthma _____ Bleeding Disorders _____ Diabetes _____ Epilepsy _____ Hepatitis(liver disease) _____ Hypertension(High Blood Pressure) _____
 Sickle Cell Anemia _____ Marfen syndrome _____ Mononucleosis - Yr _____ Kawaskis Disease _____ Handicap(Describe) _____

Please check where applicable if you have or have had any of the following:

	YES	NO		YES	NO
Head Injury, concussion or became unconscious	_____	_____	Difficulty with eyes or vision	_____	_____
Frequent or severe headaches	_____	_____	Wear contacts or glasses	_____	_____
Numbness or lack of feeling in any part of your body	_____	_____	Hearing loss or impairment, tubes or perforated eardrum	_____	_____
Stinger, burner or pinched nerve	_____	_____	False teeth, caps or braces	_____	_____
Neck, spine or low back injury or pain	_____	_____	Frequent diarrhea, black or bloody bowel movements	_____	_____
Heart murmur, racing of your heart or skipped beats	_____	_____	Kidney disease or dark or bloody urine	_____	_____
High blood pressure or high cholesterol	_____	_____	Pain swelling of muscles, tendons, joints or bones	_____	_____
Family member or relative die of heart problems or sudden death before age 50	_____	_____	Frequent nose bleeds	_____	_____
Chest pain, dizziness or passing out during exercise	_____	_____	Take long to stop bleeding when cut	_____	_____
Cough, wheezing or difficulty breathing during exercise or cold weather	_____	_____	Developed rash or hives during or after exercise	_____	_____
Difficulty running 2 miles without stopping	_____	_____	Hospitalized for any medical/surgical reason	_____	_____
Difficult exercising or become ill from exercising in the heat	_____	_____			
Loss of gain of more than 10 pounds in the last year	_____	_____	<u>FEMALE PARTICIPANT</u>		
Special diet for medical reasons	_____	_____	Absent or irregular monthly period	_____	_____
Taken any supplement, creatine, steroids or vitamins to help gain or lose weight or to improve performance	_____	_____	Require medication to control menstrual cramps	_____	_____
Smoke or chew tobacco	_____	_____	<u>MALE PARTICIPANT</u>		
			Lumps in the groin or hernia	_____	_____
			Less than two testicles	_____	_____

If you have answered yes to any of the above, please explain:

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Oxford High School Pre-participation Sports Evaluation

Physical Examination

Name _____				Date of Birth _____			
Height _____	Weight _____	% Body Fat _____	Pulse _____	BP ____/____(____/____,____/____)			
Vision: R 20/____ L 20/____		Corrected: Y N	Pupils: Equal _____	Unequal _____	Hearing _____		
HCT/HGB _____	Cholesterol _____	Urinalysis _____	Protein _____	Blood _____	Glucose _____		
Last Tetanus Booster Date _____		Last Measles (MMR) Booster _____		T.B. Test (within 3 years) _____			
Other Immunizations with dates _____							

Medical	Normal	Abnormal Findings
Appearance		
Skin		
Respiratory		
Cardiovascular		
- Arrhythmia		
- Murmur		
Abdomen		
Neurological		
Genitalia		
Physical Maturity (Tanner Stage)	1 2 3 4 5	

Orthopedic	Normal	Abnormal Findings
Neck		
Spine		
Shoulders		
Arms/Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

Recommendations

Weight loss/gain _____ Medications _____

Strengthening _____ Special Equipment _____

Stretching _____ Bracing/Taping _____

Conditioning _____

Clearance

Cleared _____

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

I certify that I have examined this student based on the requirements set by the school authorities.

Please Print M.D. _____ Date _____ Telephone _____ Signature _____