

# LOVING MUNICIPAL SCHOOLS

## ATHLETIC PARTICIPATION PHYSICAL EVALUATION FORM

Medical History—Parent /Guardian please fill out prior to examination (please use ink pen)

**Athlete's Name:** \_\_\_\_\_ **Upcoming Grade:** \_\_\_\_\_  
 (Please Print) Last First MI

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**DOB** \_\_\_\_\_ **Age** \_\_\_\_\_ **Gender:**  M  F

**Medical Provider:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Immunizations:**  Up to Date **Last Tetanus Immunization:** \_\_\_\_\_  Exempt:

YES	NO	DON'T KNOW	<b>Student Athlete Information</b>
			<b>1.</b> Has the doctor ever denied or restricted your participation in sports for any reason?
			<b>2.</b> Do you have an ongoing medical condition (like diabetes or asthma?)
			<b>3.</b> Do you have allergies to medicines, pollens, foods, or stinging insects?
			<b>4.</b> Do you have wheezing, and /or coughing spells during or after exercise?
			<b>5.</b> Do you currently take prescription or non-prescription medicines or pills?
			<b>6.</b> Have you ever passed out or had to stop exercising because of dizziness?
			<b>7.</b> Have you had severe muscle cramps or become ill when exercising in the heat?
			<b>8.</b> Have you ever had a head injury or concussion? Been knocked out?
			<b>9.</b> Have you ever had a broken bone, had to wear a cast, or had an injury to any joint?
			<b>10.</b> Were you born without or are you missing any organs (eye, kidney, testicles, etc.)?
			<b>11.</b> Have you ever been hospitalized, or had surgery?
			<b>12.</b> Do you have concerns you want to talk about to the medical provider?
<b>Females Only:</b>			
<input type="checkbox"/> YES	<input type="checkbox"/> NO		<b>13.</b> Have you ever had a menstrual period?
	IF Yes		<b>14.</b> How old were you when you had your first period? _____
	IF Yes		<b>15.</b> How many periods have you had in the last 12 months? _____

Please explain "YES" answers to questions **1** through **12:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The above information is correct to the best of my knowledge.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Concussion Management**  
 A concussion is a disturbance in the function of the brain that can be caused by a blow to the body or head and may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (headache, nausea, dizziness, memory loss, balance problem) with or without a loss of consciousness.

**I/we understand there is a concussion management protocol established that includes care and return to play criteria.**

_____	_____
Student-Athlete Signature	Date
_____	_____
Parent or Court Appointed Legal guardian signature	Date