

## SCREENING EXAM FOR ATHLETIC PARTICIPATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_

KNOWN ALLERGIES \_\_\_\_\_  
DATE OF LAST TETNUS BOOSTER SHOT \_\_\_\_\_  
CURRENT MEDICATIONS, OVER THE COUNTER DRUGS (INCLUDING VITAMINS),  
SUPPLEMENTS \_\_\_\_\_

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MEDICAL HISTORY (please check any of the following that you have experienced at anytime in the past):

- |  |   |
|--|---|
| <input type="checkbox"/> Ongoing or chronic illness  | <input type="checkbox"/> Surgery                                |
| <input type="checkbox"/> Hospitalized overnight  | <input type="checkbox"/> Passed out or dizziness after exercise |
| <input type="checkbox"/> Chest pain during exercise  | <input type="checkbox"/> Heart murmur                           |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Seizures                               |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Concussion or loss of consciousness    |
| <input type="checkbox"/> Cough, wheezing, or trouble after or during exercise                              |   |
| <input type="checkbox"/> Racing of your heart or skipped heartbeats  |   |
| <input type="checkbox"/> Family member or relative who died of heart disease or sudden death before age 50 |   |
| <input type="checkbox"/> Problems with eyes (decreased vision, eyeglasses, contact lenses)                 |   |
| <input type="checkbox"/> Orthopedic injuries (sprains, fractures, ligament damage). Please describe:       |   |

FEMALES ONLY: Have you begun menstruation? \_\_\_\_\_  
Frequency of menses \_\_\_\_\_ Length of menses \_\_\_\_\_

I certify that the above information is complete and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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PHYSICAL EXAM                      BP \_\_\_\_\_ PULSE \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

Please check if ABNORMAL and explain at bottom of page:

- |  |   |
|--|---|
| <input type="checkbox"/> Eyes/ears/nose/throat | <input type="checkbox"/> Neck                 |
| <input type="checkbox"/> Lymph nodes           | <input type="checkbox"/> Back                 |
| <input type="checkbox"/> Heart                 | <input type="checkbox"/> Shoulder/upper arm   |
| <input type="checkbox"/> Pulses                | <input type="checkbox"/> Elbow/forearm        |
| <input type="checkbox"/> Lungs                 | <input type="checkbox"/> Wrist/forearm        |
| <input type="checkbox"/> Abdomen               | <input type="checkbox"/> Hip/upper leg        |
| <input type="checkbox"/> Genitalia/hernia      | <input type="checkbox"/> Knee                 |
| <input type="checkbox"/> Skin                  | <input type="checkbox"/> Lower leg/ankle/foot |

EXPLANATION OF ABNORMALS: \_\_\_\_\_

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- Cleared for all athletic activities  
 Not cleared for all athletic activities  
Reason \_\_\_\_\_  
Restrictions/Recommendations: \_\_\_\_\_

Signature of Examiner: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed name of Examiner \_\_\_\_\_  
Address of Examiner \_\_\_\_\_

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This exam must be conducted within the twelve months prior to the start of the camp.