Student Name: (Last, First) _____ Gender: (M / F) School Year: **2016-2017** ID# _____

All sections are to be completed annually prior to high school band participation. (both in-season and out-of-season)

LISD MEDICAL HISTORY

Please answer each question by circling "YES" or "NO".

1. Do you have Sickle cell anemia? YES NO
2. Do you have a family history of Sickle Cell Anemia YES NO
3. Have you had a medical illness or injury since your last check up or sports physical? YES NO
4. Have you been hospitalized overnight in the past year? YES NO
   Have you had surgery in the past year? YES NO
5. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? YES NO
6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects) ? YES NO
7. Have you ever passed out during or after exercise? YES NO
   Have you ever been dizzy during or after exercise? YES NO
   Have you ever had chest pain during or after exercise? YES NO
   Do you get tired more quickly than your friends do during exercise? YES NO
   Have you ever had racing of your heart or skipped heartbeats? YES NO
   Have you had high blood pressure or high cholesterol? YES NO
   Have you ever been told you have a heart murmur? YES NO
   Has any family member or relative died of heart problems or of sudden unexpected death before age 50? YES NO
   Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm)? YES NO
   Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? YES NO
   Has a physician ever denied or restricted your participation in sports for any heart problems? YES NO
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? YES NO
9. Have you ever had a head injury or concussion? YES NO
   Have you ever been knocked out, become unconscious, or lost your memory? YES NO
   If yes, how many times? _____When was the last concussion? _____
   How severe was each one? (Explain below)
   Have you ever had a seizure? YES NO
   Do you have frequent or severe headaches? YES NO
   Have you ever had numbness or tingling in your arms, hands, legs, or feet? YES NO
   Have you ever had a stinger, burner, or pinched nerve? YES NO
10. Have you ever become ill from exercising in the heat? YES NO
11. Have you ever gotten unexpectedly short of breath with exercise? YES NO
    Do you cough, wheeze, or have trouble breathing during or after activity? YES NO
    Do you have asthma? YES NO
    Do you have seasonal allergies that require medical treatment? YES NO
12. Have you had any problems with your eyes or vision? YES NO
13. Are you missing any paired organs? YES NO
14. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? YES NO
15. Have you ever had a sprain, strain, or swelling after injury? YES NO
    Have you broken or fractured any bones or dislocated any joints? YES NO
    Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? YES NO

If yes, check appropriate box and explain below.

___ Head ___ Elbow ___Hip ___ Neck ___ Forearm ___ Thigh ___ Back ___ Wrist ___ Knee
___ Chest ___ Hand ___ Shin/Calf ___ Shoulder ___ Finger ___ Ankle ___Upper Arm ___Foot

16. Do you want to weigh more or less than you do now? YES NO
    Do you lose weight regularly to meet weight requirements for your sport? YES NO
17. Do you feel stressed out? YES NO
18. Record the dates of your most recent immunizations (shots) for:
    Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____
19. Are you under a doctor's care? YES NO

Females Only

20. When was your first menstrual period? _____
    When was your most recent menstrual period? _____
    How much time do you usually have from the start of one period to the start of another? _____
    How many periods have you had in the last year? _____
    What was the longest time between periods in the last year? _____

Explain "Yes" answers here: *(A "yes" on questions 1, 2, 5, 7, 11 or 17 requires a* further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required)

_____

_____

_____

LISD PRE-PARTICIPATION PHYSICAL EXAMINATION

Height _____ Weight_____ % Pulse_____ BP____/____ (____/____, ____/____)
Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINIDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart-Auscultation of the heart in the supine position		
Heart-Auscultation of the heart in the standing position		
Heart-Lower extremity pulse		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE {Please check one}

☐ **Cleared (No restrictions)**

☐ Cleared **after** completing evaluation/rehabilitation for: _____

☐ ***Not cleared*** **-** Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, Examination forms signed by any other health care practitioner will not be accepted.

Physician Name (print/type): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____**Phone Number:** _____

Physician Signature**:** _____ **Date:** _____