Well Child/Sports or School Evaluation

Please complete in ink

Student Name____________________
Address:____________________
City/State:____________ Zip:____________
Telephone:____________ Male______ Female______
Date of Birth:____________ Age:____________
Grade:____________ School:____________

PLEASE COMPLETE PRIOR TO EXAMINATION

HISTORY

	Yes	No
1. Have you ever fainted?	☐	☐
Have you ever fainted during exercise?	☐	☐
Have you had chest pain during exercise?	☐	☐
2. Has anyone in your family died suddenly?	☐	☐
Before age 35?______ Before age 50?______		
Cause____________		
3. Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury?	☐	☐
If yes, how many times? ______		
4. Have you ever had a stroke or heat exhaustion?	☐	☐
5. Do you wheeze or cough during or after exercise?	☐	☐
Do you have any history or asthma?	☐	☐
6. Do you have any allergies? (medications, bee sting, pollens, etc.)	☐	☐
7. Any injuries since last exam?	☐	☐
If yes, list injuries:____________		
8. Do you take any medications? (including vitamins and nonprescription drugs)____________	☐	☐
9. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
10. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
If yes, explain. ____________		
11. Do you use seat belts on a regular basis?	☐	☐
12. Do you use tobacco or alcohol?	☐	☐

13. If female, when was your first menstrual period?__________
When was your most recent menstrual period? __________
14. In the last year, what was your:
Lowest weight __________ Your highest weight__________
15. Immunizations: see attached immunization form
16. Circle any of the following you have had:

Abnormal bleeding/bruising	Anemia
Broken bones/stress fracture	Diabetes
Dislocation (shoulder, etc.)	Hearing impairment
Heart murmur/palpitations	Hepatitis/jaundice
High blood pressure	Loss of eye sight
Rheumatic fever	Scoliosis
Seizures	Sickle-cell disease
Single organs (kidney, eye, etc.)	Undescended testicle
Other__________	None of the above

Additional Comments:____________________

Greater Nebraska Medical & Surgical Services
2091 Box Butte, Suite 700
Alliance, NE 69301
308-762-7244

VITAL SIGNS:

Ht.________ Wt.________ BP______/______ Pulse________

Vision R______ L______ Both______ Corrected/Uncorrected

MEDICAL EXAM:

	Normal	Abnormal	Comments
HEENT			
Eyes			
Ears			
Nose			
Throat			
Dental			
Thyroid			
Nodes			
Lungs			
Heart/Murmurs			
Abdomen			
Genitalia (Males)			
Hernia			
Skin			
Neck			
Upper Extremities			
Back/Spine			
Lower Extremities			
Neuro			

LABS:

UA dip Pr______ Sug______

Certification for Participation in Physical Education/Athletic Activities

I hereby certify that the student names above has been evaluated as indicated by the above record to be physically fit to participate in physical education activities and/or interscholastic athletics, except as noted below. Any exceptions or required modifications should be re-evaluated annually or as specified.

Modifications or exceptions:____________________

☐ Deferred pending further evaluation for ____________.
☐ A copy of this form should go with this individual to all sporting activities.

Required Medication:____________________

Physician Signature:____________________

I do not know of any existing physical condition or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize release to the school nurse/coach of the information contained in this document. Upon written request, I may receive a copy of this document for my personal health care provider.

Student Name____________________

Signature ____________________ Date ________
(Parent or Legal Guardian)