Students run LA®

Physical Screening Form 09-10

Student Name: _____
(please print)
Birth Date: _____

School/Group: _____

Phone Number: _____

Age: _____ **Gender:** _____

Parent/Guardian must complete all the information down to **the dotted line and sign** below before student is examined.

Medical History: Parent/Guardian **must** answer all questions with a "yes" or "no" in order to make physical form valid for SRLA participation.
'Yes' answers to the following questions must be answered in detail and include date(s). Use reverse side if necessary.

1. Have you ever sustained an injury, which prevented you from playing sports for more than one day? _____Yes _____No

2. Have you had any injuries, pain or swelling to the following areas? (circle 'y' for yes and "n' for no)

Y N Head	Y N Chest	Y N Elbow	Y N Forearm	Y N Hand	Y N Hip	Y N Knee	Y N Ankle
Y N Neck	Y N Shoulder	Y N Upper Arm	Y N Wrist	Y N Finger	Y N Thigh	Y N Shin/Calf	Y N Foot
Y N Back	Y N Other:_____						

3. Do you have a history of and/or take medication (specify) for any medical problem such as: (circle 'y' for yes and "n' for no)

Y N Allergy	Y N Dizziness	Y N Heart Murmur	Y N Concussion	Y N Asthma	Y N Illness from heat	Y N Viral Infection	
Y N Rash or Hives	Y N Chest Pain	Y N High Blood Pressure	Y N Seizure	Y N Difficulty Breathing	Y N Broken Bone	Y N Numbness	
Y N Fainting	Y N Easily tired	Y N High Cholesterol	Y N Severe Headaches	Y N Skin Condition	Y N Dislocated Joint	Y N Surgery/Hospitalization	
Y N Diabetes	Y N Other:_____						

4. Are you allergic to any medication such as (circle) Penicillin, Iodine, Novacaine, or other medications? _____

5. Any family history of medically unexplained or cardiac caused sudden death under age 50? ____Yes ____No

6. Any family history of Long QT Syndrome or unexplained fainting or seizures? ____Yes ____No

I, (print name) _____, give my consent on behalf of my son/daughter, or the minor for whom I am legal guardian, as set forth above, to participate in and receive a physical screening exam. This exam may include an unclothed exam by a licensed health provider as well as urine, vision, & blood pressure screening. I understand that this exam is intended for the purpose of screening for participation in Students Run L.A. marathon training program. I also consent to the release of information by the screening institution to representatives of Students Run L.A. In addition, I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Parent/Guardian Signature: _____ **Date:** _____

For Physician Use Only -

History O.K. ( ) Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temp:_____ Resp: _____

General Appearance: ( ) well nourished and well developed

Medical

Eyes: ( ) N ( ) Ab _____
Ears: ( ) N ( ) Ab _____
Nose: ( ) N ( ) Ab _____
Throat: ( ) N ( ) Ab _____
Lymph Nodes: ( ) N ( ) Ab _____
Pulses: ( ) N ( ) Ab _____
Heart: ( ) N ( ) Ab _____
Lungs: ( ) N ( ) Ab _____
Abd: ( ) N ( ) Ab _____
Hernia: ( ) N ( ) Ab _____
Skin: ( ) N ( ) Ab _____

Musculoskeletal

Neck: ( ) N ( ) Ab _____
Back: ( ) N ( ) Ab _____
Shoulder/Arm: ( ) N ( ) Ab _____
Elbow/Forearm: ( ) N ( ) Ab _____
Wrist/Hand: ( ) N ( ) Ab _____
Hip/Thigh: ( ) N ( ) Ab _____
Knee: ( ) N ( ) Ab _____
Leg/Ankle: ( ) N ( ) Ab _____
Foot: ( ) N ( ) Ab _____

Females Only – Most recent menstrual period: _____

Impression:

( ) Satisfactory Screening Exam ( ) Recommend Further Evaluation: 1) Reason: _____
2) May continue to train? _____Yes _____No

Physician Signature: _____Physician Name (print): _____Date: _____

*****The exam must have a DATE and PHYSICIAN STAMP and SIGNATURE.*****