VIRGINIA COMMONWEALTH UNIVERSITY

EVALUATION FOR PARTICIPATION IN VARSITY SPORTS

****

TODAY'S DATE: _____/_____/_____ SPORT: _____

NAME: _____ CLASS/YEAR: _____

SOC. SEC. #: _____-_____-_____ GENDER: _____

DATE OF BIRTH: _____/_____/_____
Month Day Year

Permanent Address:

STREET: _____

CITY: _____

STATE: _____ ZIP: _____

COUNTRY: _____

Local (VCU) Address:

STREET: _____

CITY: _____

STATE: _____ ZIP: _____

LOCAL PHONE: (____)_____-_____

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PARENTS: _____

PHONE(H): (____)_____-_____

PHONE(W): (____)_____-_____

OTHER CONTACT: _____

PHONE(H): (____)_____-_____

PHONE(W): (____)_____-_____

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INSURANCE CO.: _____ POLICY #: _____

PRIMARY CARE DOCTOR: _____ PHONE: (____)_____-_____

Health History (To be completed by student and parents prior to examination)

Date of Last Tetanus Booster Shot: _____/_____/_____

	Yes	No	Have you ever had or currently have:
1.	____	____	Chronic or recurrent illness?
2.	____	____	Illness lasting longer than 1 week?
3.	____	____	Hospitalizations?
4.	____	____	Surgery?
5.	____	____	Missing organs (eye, kidney, testicle)?
6.	____	____	Ear, nose or throat problems?
7.	____	____	Diabetes, thyroid or other endocrine problems?
8.	____	____	Stomach or bowel problems?
9.	____	____	Kidney or bladder problems?
10.	____	____	Asthma?
11.	____	____	Hepatitis?
12.	____	____	Anemia?
13.	____	____	Sickle cell trait or other blood disorder?
14.	____	____	Anorexia or Bulimia?
15.	____	____	Sexually transmitted diseases?
16.	____	____	Irregular menstrual periods? (Females only)
17.	____	____	Heat exhaustion, heat stroke?

	Yes	No	Do you:
18.	____	____	Wear eyeglasses or contact lenses?
19.	____	____	Wear dental bridges, braces or plates?
20.	____	____	Wear any type of brace or support to play?
21.	____	____	Have any type of screw, pin or plate in your body?
22.	____	____	Take any medication?
23.	____	____	Take any performance enhancing drugs or supplements?
24.	____	____	Have any allergies to medicine (e.g. Penicillin, Sulfa)?

	Yes	No	Have you ever had or currently have:
25.	____	____	High blood pressure?
26.	____	____	Heart disease?
27.	____	____	Chest pain with exercise?
28.	____	____	Cough with exercise?
29.	____	____	Dizziness or fainting with exercise?
30.	____	____	Head injury, concussion or loss of consciousness?
31.	____	____	Frequent headaches?
32.	____	____	Seizures, convulsions?
33.	____	____	Facial injury?
34.	____	____	Neck injury?
35.	____	____	Low back pain or injury?
36.	____	____	Shoulder injury or surgery?
37.	____	____	Elbow injury?
38.	____	____	Wrist/Hand injury?
39.	____	____	Hip injury?
40.	____	____	Knee injury or surgery?
41.	____	____	Ankle injury?
42.	____	____	Muscle injury?
43.	____	____	Fractures (broken bones or stress fracture)?

	Yes	No	**Family History:**
44.	____	____	Has any family member died suddenly? At what age? _____
45.	____	____	Has any family member had a heart attack? At what age? _____
46.	____	____	Has any family member been diagnosed with Marfan's syndrome?

Continued On Back

Use this space to explain any "**YES**" answers to the numbered questions in the **HEALTH HISTORY** on the other side or to provide any additional pertinent information (Please be specific and include dates and side of injury): _____

_____

_____

_____

_____

_____

PHYSICAL EXAMINATION

Height _____ Weight _____ Pulse rate _____ Blood pressure _____ / _____
Vision: Without _____ With corrective lenses _____
Right _____ / _____ Left _____ / _____

	Normal	Abnormal	Not Examined	Comments
1. Eyes				
2. Ears, nose, throat				
3. Mouth, teeth				
4. Neck				
5. Chest, lungs				
6. Cardiovascular				
7. Back				
8. Abdomen				
9. Genitalia, hernia				
10. Skin, lymphatics				
11. Shoulders				
12. Arms, hands				
13. Hips, thighs				
14. Knees				
15. Ankles				
16. Feet				
17. Neurological				

Laboratory tests (as indicated) _____

PARTICIPATION RECOMMENDATIONS

❑ No history or physical findings on this exam would prohibit this student from participating in the sports requested. Comments: _____

_____

❑ This student should have the following health problem(s) evaluated or treated before participation recommendations can be made: _____

_____

❑ This student has health problem(s) that prohibit him/her from participating in the requested sport of _____ *however,* this student can participate in the following requested sport(s):

_____

_____ _____
Examiner's Signature Examiner's Printed Name

_____ _____
Date of Physical Examination Address

(_____)_____ _____
Telephone City, State, Zip

Form adapted from: American Academy of Pediatrics/Ross Labs Evaluation for Participation in Sports, 1987.