

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 FINDINGS
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:** _____