HEALTH APPRAISAL FOR ATHLETES

NAME:	DATE OF EXAM:
STUDENT NUMBER/SSN:	DOB:

ADDRESS:	PHONE:	SPORT:

STUDENT TO COMPLETE THIS SECTION*

EMERGENCY CONTACTS (Name and Phone Number): ____

____

____

Have you had a serious illness or injury in the past 6 months?:

NO____ YES (Explain) ____

Comment on all "Yes" answers:

	YES	NO	Comment
Seizures	____	____	
Headaches/Dizziness	____	____	
Ear Disease	____	____	
Glasses/Contacts during Play	____	____	
Skin Problems	____	____	
Back Pain	____	____	
Medications	____	____	
Ever smoke cigarettes	____	____	
Asthma	____	____	
Drink Alcohol	____	____	
Use Street Drugs	____	____	

	YES	NO	Comment
Heart Problems	____	____	
High Blood Pressure	____	____	
Blood relatives who died from Heart problems before age of 50	____	____	
Absent Organs	____	____	
Allergies	____	____	
Diabetes	____	____	
Bleeding Problem	____	____	
Anemia	____	____	
WOMEN ONLY			
Menstrual Cramps	____	____	
Date of Last Period	__________		

INJURIES	YES	NO	DATE OF INJURY	TREATMENT
Concussion/Head Injury	____	____	__________	____
Skull Fracture	____	____	__________	____
Neck Injury	____	____	__________	____
Loss of Tooth	____	____	__________	____
Back Injury	____	____	__________	____
Arm Injury	____	____	__________	____
Should Injury	____	____	__________	____
Knee Injury	____	____	__________	____
Ankle Injury	____	____	__________	____

STUDENT SIGNATURE: ____

*****Medical Provider must complete back of sheet*****

Please attach a copy of both sides of your insurance card.

PHYSICIAN EVALUATION

NAME:____________________ SS#:______________________

IMMUNIZTIONS/SCREENING

1. MMR 1) ________ 2) _________	**4. DT**
2. MENINGITIS	**5. HEP B**
3. PPD DATE: ☐ **Pos ____** ☐ **Neg _____** **X-Ray Date ______** ☐ **Normal**	**6. VARICELLA** ☐ **DISEASE** ☐ **VACCINE ___________**
VISION **CORRECTED** ☐ **UNCORRECTED** ☐	**B ________ R ________ L ________** **B ________ R _________ L ________**

ALLERGIES ____

MEDICATION & SUPPLEMENTS (LIST ALL) ☐ **NONE**

____

____

____

PHYSICAL EXAM (Please review Patient History on front page)

HT_______ WT_______ BP________

	Normal	Abnormal	Comment on ALL *abnormal* answers:
Pupils	____	____	
Ears: (swimmers only)	____	____	
Nodes:	____	____	
Lungs:	____	____	
Heart:	____	____	
Abdomen:	____	____	
GU (male only)	____	____	
Skin:	____	____	
Orthopedic Evaluation:			
Neck:	____	____	
Shoulders:	____	____	
Back:	____	____	
Hamstrings:	____	____	
Knees:	____	____	
Ankles:	____	____	
Other:	____	____	

MEDICAL RECOMMENTATION:

☐ No medical or orthopedic contraindication to Sports/PE

☐ Restrictions ____

☐ Other ____

Provider Signature______________________Provider Name______________________Date__________

Provider Address & Phone Number:____

******RETURN COMPLETED FORM TO DOUG HENNENBERG, ATHLETIC TRAINER MCC Health & Physical Education Dept., 1000 East Henrietta Rd., Rochester, NY 14623**

For more information visit our website at:
http://www.monroecc.edu/depts/stuhealth/staywell/immune.htm#athletes