Bishop O'Connell High School
Sports Preparticipation Evaluation
Medical History

This information should be completed by the parent and student prior to the physical examination.

Student's Last Name _____ First Name _____ Male____ Female ____

Date of Birth ____/____/____ Sport(s)_____

Allergies_____

Date of last Tetanus shot _____/_____/_____

Has student ever had any of the following—explain "Yes" answers:

Heart murmur	Yes ☐	No ☐	_____
High blood pressure	Yes ☐	No ☐	_____
Other heart problems	Yes ☐	No ☐	_____
Relative with heart problems	Yes ☐	No ☐	_____
Dizziness, chest pain or passed out after exercise	Yes ☐	No ☐	_____
Concussion	Yes ☐	No ☐	_____
Been knocked out	Yes ☐	No ☐	_____
Seizures or epilepsy	Yes ☐	No ☐	_____
Muscle, bone or joint injuries	Yes ☐	No ☐	_____
Surgery	Yes ☐	No ☐	_____
Been hospitalized	Yes ☐	No ☐	_____

Does student currently have any of these conditions—explain "Yes" answers:

Trouble breathing or cough after exercise	Yes ☐	No ☐	_____
Significant allergies	Yes ☐	No ☐	_____
Asthma	Yes ☐	No ☐	_____
Adrenaline/inhaler prescription	Yes ☐	No ☐	_____
Take medicine regularly	Yes ☐	No ☐	_____
Illness lasting a week or more	Yes ☐	No ☐	_____
Blood disorder	Yes ☐	No ☐	_____
Contacts, glasses, braces	Yes ☐	No ☐	_____
Missing/Non-functioning organ	Yes ☐	No ☐	_____
Skin problem	Yes ☐	No ☐	_____
Special equipment for sports	Yes ☐	No ☐	_____
Any other significant health problem	Yes ☐	No ☐	_____

Date _____/_____/_____

Signature of Student _____

Signature of Parent/Guardian _____

Sports Preparticipation Evaluation
Physical Examination

To be completed and signed by the student's physician

Student's Last Name _____ First Name _____ Date of Exam ____/____/____

Height _____ Weight _____ Resting Pulse _____ BP _____/_____

Vision R 20/_____ L 20/_____ Corrected ☐ Yes ☐ No

Normal -- please put a check mark below **Abnormal Findings** -- please explain in space provided below

_____ Heart: _____
_____ Pulse: _____
_____ Lungs: _____
_____ Skin: _____
_____ Lymphatic: _____
_____ Abdomen: _____
_____ Genitalia/Hernia: _____
_____ Eyes: _____
_____ Ears: _____
_____ Nose: _____
_____ Throat: _____
_____ Neck: _____
_____ Back: _____
_____ Shoulders: _____
_____ Elbows/Wrists/Hands: _____
_____ Hips/Knees: _____
_____ Ankles/Feet: _____

Optional when medically indicated:

Tanner Stage: 1 2 3 4 5 Percent Body Fat: _____

Labs: Urine _____ Labs: Hemoglobin/HCT: _____

TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease
□ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: □ Positive □ negative

CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ □ Normal □ Abnormal

Clearance for Sports

_____ Full Participation

_____ Needs additional evaluation/rehabilitation for_____

_____ Limited/No participation due to _____

Physician's Name (please print) _____ Physician's Signature_____

Date_____ Office Phone Number (_____)_____