



SAISA SPORTS ELIGIBILITY
HEALTH HISTORY AND PHYSICAL EXAMINATION

Name of Student: _____ Sex: M / F

Date of Birth: mm / dd / yyyy Age: _____ Year of Graduation: _____ Date: mm / dd / yyyy

Sport(s): List all _____

A. HEALTH HISTORY To be completed by parents and student.

Yes No Check Yes or No to questions 1-27 and explain all "Yes" answers.

- 1. Are you presently taking any medications? List:
What is the medication for?
2. Do you have any chronic or recurrent medical conditions?
3. Have you had any surgery?
4. Do you have any missing organs other than tonsils (appendix, eye, etc.)?
5. Do you have any allergies/conditions that are life threatening or affect school/sports?
6. Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
7. Have you had any problem with your blood pressure or heart?
8. Do you have any skin problems?
9. Have you ever had fainting, convulsions, seizures or severe dizziness?
10. Have you ever had asthma or trouble breathing or cough during exercise?
11. Do you wear corrective lenses (glasses/contact lenses) or protective eye wear?
12. Do you have a significant vision or hearing problem?
13. Do you wear any dental appliance such as braces, retainer, plate, bridge?
14. Females: Have you had any menstrual problems?
15. Do you have any other medical concern?

* Students with asthma require Asthma Health Care Plan. Students with life threatening allergy require Allergy Health Care Plan. Students with other conditions (i.e. diabetes, epilepsy) require Health Care Plan/Authorization for Medication.

B. SPORTS/INJURY HISTORY

- 16. Have you had any concerns about participating in your sport(s)?
17. Have you ever had injuries requiring treatment by a physician?
18. Have you ever had a knee injury?
19. Have you ever had an ankle injury?
20. Have you ever had a broken bone (fracture)?
21. Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
22. Have you ever had a cast, splint, or had to use crutches?
23. Must you use special equipment for competition (pads, braces, etc.)?
24. Has it been more than 5 years since your last tetanus booster shot?
25. Have you NOT been immunized against hepatitis B?
26. Have you ever had a neck/head injury? When?
27. Have you ever had a heat related problem (heat exhaustion, heat stroke)?

Parents/Students: DO NOT WRITE BELOW THIS LINE

Examiner's comments on all "Yes" answers (refer to number):

Name of Student: _____

C. PHYSICAL EXAMINATION *Performed by licensed doctor or nurse practitioner.*

Height: _____ Weight: _____ BMI: _____ BP: _____ mmHg Pulse: _____ /min

Visual Acuity: Uncorrected R: 20/ _____ L: 20/ _____ Corrected R: 20/ _____ L: 20/ _____

by wearing Glasses Contact lenses

| | Normal | Abnormal | Comments |
|------------------------------|--------------------------|--------------------------|----------|
| Head, neck | <input type="checkbox"/> | <input type="checkbox"/> | |
| Eyes (pupils) ENT | <input type="checkbox"/> | <input type="checkbox"/> | |
| Teeth, gums | <input type="checkbox"/> | <input type="checkbox"/> | |
| Chest | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lungs | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart | <input type="checkbox"/> | <input type="checkbox"/> | |
| Abdomen | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spine (scoliosis), back | <input type="checkbox"/> | <input type="checkbox"/> | |
| Shoulders, upper extremities | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hips, lower extremities | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neurological | <input type="checkbox"/> | <input type="checkbox"/> | |
| Emotional/mental health | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nutritional status | <input type="checkbox"/> | <input type="checkbox"/> | |
| Developmental status | <input type="checkbox"/> | <input type="checkbox"/> | |

D. RECOMMENDATIONS

Yes No

Approved for participation in age appropriate **competitive sports**

If no, describe restrictions or precautions _____

Name of examiner: _____ Signature: _____

Address: _____ Designation: MD / MBBS / NP (*circle*)

Email: _____ Date: _____ (*mm/dd/yyyy*)