2021-2022
School & Sports Qualifying Screening Evaluation

PLEASE COMPLETE IN INK

Student Name: _____

Address: _____

City, Zip: _____ Telephone:_____

Grade:_____ School: _____

School: Marian High School

Address: 7400 Military Ave.

Phone: (402) 571-2618 FAX: (402) 572-8028

PLEASE COMPLETE PRIOR TO EXAMINATION

HISTORY:	YES	NO
*1. Have you ever fainted?	☐	☐
Have you ever fainted during exercise?	☐	☐
Have you had chest pain during exercise?	☐	☐
*2. Has anyone in your family died suddenly?	☐	☐
Before age 35? _____ Before age 50? _____		
Cause: _____		
*3. Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury?	☐	☐
*4. Have you ever had heat stroke or heat exhaustion?	☐	☐
*5. Do you wheeze or cough during or after exercise?	☐	☐
Do you have any history of asthma?	☐	☐
*6. Do you have any allergies? (medications, bee sting, pollens, etc.) _____	☐	☐
*7. Any injuries since last exam?	☐	☐
If yes, list injuries: _____		
*8. Do you take any medication? (include vitamins and nonprescription drug) _____	☐	☐
*9. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
10. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
If yes, explain _____		
11. When was your first menstrual period? _____		
When was your most recent menstrual period? _____		
12. In the least year, what was your		
Lowest weight: _____ Highest weight _____		
What do you think is your ideal weight: _____		
13. Immunizations: Last tetanus _____		
Measles, Mumps, Rubella (MMR) (1) _____ (2) _____		
Hepatitis B (1) _____ (2) _____ (3) _____		

14. Circle any of the following you have had:

Abdominal bleeding/bruising	Amenia
Broken bones/stress fractures	Diabetes
Dislocation (shoulder, etc.)	Hearing impairment
Heart murmur/palpitations	Hepatitis/jaundice
High blood pressure	Loss of eye sight
Rheumatic fever	Scoliosis (curvature of spine)
Seizures	Sickle-cell disease
Single organs (kidney, eye, etc.)	
Other _____	

☐ I have had none of the above problems

15. Do you use seat belts on a regular basis?	☐	☐
16. Do you use tobacco or alcohol?	☐	☐
17. Are there any concerns you would like to discuss? (Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other?)	☐	☐

* MUST BE ANSWERED FOR PARTICIPATION IN ATHLETICS

Additional Comments: _____

_____

Student's Signature: _____

Date: _____

EXAMINATION:

HT: _____ WT: _____ BP _____/_____

PULSE: _____ VISION: R _____ L _____

MEDICAL EXAM (cross out if omitted)	**Normal**	**Abnormal**	**Concerns**
Eyes			
Ears			
Nose			
Throat			
Dental			
Thyroid			
Nodes			
Lungs			
Heart/Murmurs			
Abdomen			
Hernia			
Skin			
Neck			
Upper Extremities			
Back/Spine			
Lower Extremities			
Nuero			

Certification for Participation in Physical Education/Athlete Activities

I hereby certify that the student named above has been evaluated as indicated by the above record to be physically fit to participate in physical education activities and/or Interscholastic athletics except as noted below.
Any exceptions or required modifications should be re-evaluated annually or as specified.

Modifications or exceptions: _____

_____

☐ Deferred pending further evaluation for _____

Physician Signature: _____

Date: _____

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purpose of participation in athletics and activities.

Parent Signature: _____

Date: _____