DATE: ___/___/___

FORT SMITH PUBLIC SCHOOLS
ATHLETIC COMPETITION HEALTH SCREENING FORM

NAME: _____ FAMILY PHYSICIAN: _____

SCHOOL: _____ SPORTS: _____

AGE: _____ GRADE: _____

DATE OF BIRTH: ___/___/___ SEX: F ☐ M ☐

ATHLETE HEALTH HISTORY

Answer "yes" or "no" ONLY	YES	NO
Chronic /Recurrent Illness?		
Hospitalization?		
Surgery Other Than Tonsils?		
Injuries Treated by Physician?		
Current Medications?		
Organs Missing?		
Heat Exhaustion/Stroke?		
Dizziness, Fainting, Convulsions and/or Headaches?		
Concussion?		
Knocked Out?		
Wears Glasses or Contacts?		
Hearing Defects?		
Problems with Liver, Spleen, Kidneys?		
Problems with Blood Pressure, Heart or Heart Murmurs?		
Hernia		
Bone/Joint Injury?		
Sprains/Dislocations?		
Allergy to Medications? Name:		
Asthma?		
Tetanus Booster in the last 10 years?		

Vitals	Physical Evaluation Comments	Recommended Follow-up
Ht: in Wt. lbs. BP ___/___		
General		
Head	Orthopaedic Evaluation	
Eyes	Summary of Comments:	
ENT		
Heart		
Abdomen	Sports Participation Approved YES ☐ NO ☐	
Genitalia		
Allergy		
Extremity Back Neck	Limitations:	

_____ Parent or Guardian Signature

_____ Physician Signature