

OKINAWA DODDS SPORTS PRE-PARTICIPATION HEALTH EXAMINATION

A Service of the Pediatric and Family Practice

Departments of Lester U.S. Naval Hospital

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/ School \_\_\_\_\_  
Last Name First Name MI Grade \_\_\_\_\_

FP / Sponsor's SSN Records kept at

Age \_\_\_\_\_ DOB \_\_\_\_-\_\_\_\_-\_\_\_\_. Race \_\_\_\_\_ Sex \_\_\_M\_\_\_F

This application to complete in interscholastic athletics is voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations.

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_/\_\_\_\_\_  
Date Student Signature

**PARENT'S OR GUARDIAN'S PERMISSION RELEASE**

I hereby give my consent for the above named student to participate in this exam and his/her school athletic activities, except those indicated on this form by the examining physician, physician assistant, or nurse practitioner, provided that such athletic activities are approved by the school.

This per-participated sports history and physical examination is for the express purpose of determining the appropriate level of athletic participation of the student in established athletic programs. This examination is not intended to be a complete medical evaluation or include all screening tests and well child care appropriate to the age of the student. These facets of your child's medical care need to be addressed specifically at other appointments with medical providers. A normal history and physical examination or clearance to participate does not predict that your child will be free from injury or illness if he/she participates. The Pediatric and Family Practice Department of Lester Naval Hospital have no responsibility to provide first aid at any of the games or practice sessions. The parents understand that the risk of injury is assumed by the student and parents when they execute this form.

\_\_\_\_\_  
Printed name of parent / guardian Signature of parent / guardian

GENERAL PHYSICAL EXAM CONTINUED:  
COMMENTS: (by term #)

ASSESSMENT:

**PARTICIPATION RECOMMENDATIONS**

- 1. \_\_\_ There were no history or physical findings with should prohibit this student from participating in scholastic athletics.
- 2. \_\_\_ The following problems must be evaluated or treated prior to participating in scholastic athletics.
- 3. \_\_\_ This student has health problems that prohibits and disqualifies him/her from scholastic athletics.

**FOLLOW UP, RECOMMENDATIONS, PREVENTIVE MEASURES, TREATMENTS**

- 1. \_\_\_ ROUTINE, as needed for health maintenance evaluations.
- 2. \_\_\_ Make follow up appointment
- 3. \_\_\_ Additional Medical Plans / Instructions for prevention of injuries

\_\_\_\_\_  
Medical Officer

## Medical History

to be completed by students and parents prior to any examination

	yes	no	Has this student had any:		yes	no	Has this student had any:
1.	___	___	Chronics/ recurrent illness?	13.	___	___	Wear Glasses (contact lenses)?
2.	___	___	Illness lasting over 1 week?	14.	___	___	Wear dental bridges / braces/ plates)?
3.	___	___	Hospitalized?	15.	___	___	Take any medication?
4.	___	___	Surgery?	16.	___	___	Injuries requiring a doctor's Attention?
5.	___	___	Missing organs (eye, kidney, testicles)?	17.	___	___	Neck injuries?
6.	___	___	Meditation allergy?	18.	___	___	Knee injury?
7.	___	___	Problems with the heart or blood pressure?	19.	___	___	Knee surgery?
8.	___	___	Chest pain with exercise?	20.	___	___	Ankle injury?
9.	___	___	Dizziness or fainting with exercise?	21.	___	___	Other serious injury?
10.	___	___	Dizziness / fainting frequent headaches or convulsions?	22.	___	___	Broken Bones? (Fractures)?
11.	___	___	Concussion / unconsciousness?	23.	___	___	Is there any reason why this student should not participate in sports?
12.	___	___	Heat exhaustion, heat strokes, or other problems with heat?	24.	___	___	Has any family member died suddenly of causes other than an accident?
				25.	___	___	Has any family member had a heart attack at less that 55 years of age?

Date of last known Tetanus shot: \_\_\_\_\_

Is there anything else you would like to note or discuss with your doctor? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_ Pulse \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Distant Visual Acuity R 20 / \_\_\_\_\_ L 20 / \_\_\_\_\_

### General Physical Exam

	Normal	abnormal	Not examined
1. Eyes	_____	_____	_____
2. ENT	_____	_____	_____
3. Mouth, Teeth	_____	_____	_____
4. Neck	_____	_____	_____
5. Chest	_____	_____	_____
6. Lungs	_____	_____	_____
7. Cardiovascular	_____	_____	_____
8. Abdomen	_____	_____	_____
9. Genitalia/Hernia	_____	_____	_____
10. Sexual Maturity	_____	_____	_____
11. Skin, Lymphatics	_____	_____	_____
12. Spine	_____	_____	_____
13. Shoulders	_____	_____	_____
14. Arms, Hands	_____	_____	_____
15. Hips	_____	_____	_____
16. Thighs	_____	_____	_____
17. Knees	_____	_____	_____
18. Ankles	_____	_____	_____
19. Feet	_____	_____	_____
20. Neurological	_____	_____	_____
21. Other	_____	_____	_____