

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

OTSG APPROVED (Date)

SCHOOL, SPORTS & CAMP EXAM FORM (Grades 7-12 & College)

Evans Army Community Hospital, Ft. Carson, CO 80913 Ph 526-7150/7140

Name _____ Date _____

Age _____ Sports _____

- | | YES | NO |
|---|-----|-----|
| 1. Do you have any allergies (medicine, bees, etc)?..... | ___ | ___ |
| 2. Do take any medications on a regular or daily basis?..... | ___ | ___ |
| 3. Do you have any problems that require regular medical care?... | ___ | ___ |
| 4. Have you had any surgery or operations?..... | ___ | ___ |
| 5. Have you ever had a serious injury?..... | ___ | ___ |
| 6. Have you ever lost consciousness, passed out, been knocked out or had a seizure?..... | ___ | ___ |
| 7. Have you ever had an injury to a bone, muscle, joint or nerve that still causes you problems or has not healed well (this includes sprains, strains, fractures, dislocations, burner or stinger)?..... | ___ | ___ |
| 8. Do you or does anyone in your family have heart problems?..... | ___ | ___ |

Explain yes answers from above: _____

Height _____ % Weight _____ % BP _____ Pulse _____

Vision (if done) R 20/_____. L 20/_____ corrected Y / N

Normal	Note abnormal findings
HEENT _____	
Dental _____	
Heart _____	
Lungs _____	
Abdomen _____	
GU _____	
Musc-skel _____	

Immunizations needed _____

- Clearance: A. Clearance for all Supervised sports and activities.
 B. First need evaluation/rehabilitation for _____
 C. Not cleared for (circle appropriate ones) Collision, contact,
 Strenuous sports, or the following sports: _____

Notes/Recommendations: _____

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

- | | |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

PART A

Name of Sponsor	Home Telephone	Duty/Work Telephone
	Cell Telephone	
Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex
		<input type="checkbox"/> Male <input type="checkbox"/> Female

Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

Yes No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

Yes No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Other problems (list below)		
13. Chest pain with exercise					

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: SPORTS PHYSICAL

Medical Staff Assessment (Completed by licensed independent practitioner)

Age YRS	MOS	Height _____ cm. (_____%ile)	Weight _____ kgs. (_____%ile)
BP: P:	/	Visual Acuity Right / Left /	Tested with / without glasses
		NORMAL	ABNORMAL
		N / A	COMMENTS
1. Eyes			
2. Ears, Nose & Throat			
3. Hearing			
4. Mouth & Teeth			
5. Neck (Soft tissues)			
6. Cardiovascular			
7. Chest & Lungs			
8. Abdomen			
9. Genitalia – Hernia			
10. Skin & Lymphatics			
11. Spine – Scoliosis			
12. Extremities			
13. Neurological			
14. Wears braces / plates			

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: Yes No

PARTICIPATION RECOMMENDATIONS

All sports ____ Yes ____ No Normal physical activity to including PE
 PA Additional comments: Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? Yes No

Date Licensed Health Care Professional Stamp Licensed Health Care Professional Signature

Date Type or print name of Parent or Guardian Signature of Parent or Guardian

Health Assessment Re-Certification

Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	