

STUDENT HEALTH RECORD/PHYSICIANS REPORT

*To be completed by Parent or Legal Guardian


STUDENT NAME: _____

Does student have on-going illness such as diabetes?	YES	NO	
Has student ever had rash/hives develop during exercise?	YES	NO	DATE:
Does student have current skin problems? (warts, acne, fungus, itching, etc)	YES	NO	DATE:
Has student ever had a head injury or concussion?	YES	NO	DATE:
Has student ever been knocked out, been unconscious or lost memory?	YES	NO	DATE:
Has student ever had a seizure?	YES	NO	DATE:
Does student have frequent or severe headaches or migraines?	YES	NO	DATE:
Has student ever had numbness or tingling in arms, hands, legs, or feet?	YES	NO	DATE:
Does student cough, wheeze or trouble breathing during or after activity?	YES	NO	DATE:
Does student have asthma?	YES	NO	DATE:
Does student or family member ever had adverse reaction to anesthesia?	YES	NO	DATE:
Does student have or did they have a history of an eating disorder?	YES	NO	DATE:
Does student have history or currently have any mental health issues? (ex: depression, anxiety, stress ADD/ADHD)	YES	NO	DATE:

Explain all "YES answers: _____

LIST ANY SURGERIES OR HOSPITALIZATIONS

DATE	SURGERY	HOSPITALIZATION

	<p>SUNASKEO C/O Evans Kurth Holdings LLC PO Box 248 Frisco, TX 75034 Ph: 469-633-9202 Fax:469-570-4480</p>
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STUDENT NAME: _____

ORTHOPEDIC HISTORY:

Please provide any previous injuries your student has suffered: Include dates, surgeries, special tests (CAT Scan, x-ray, MRI, etc), Right or Left body part.

INJURY	TEST/SURGERY/TREATMENT
HEAD (includes ear, teeth, nose, eyes)	
NECK:	
BACK:	
CHEST:	
SHOULDERS:	
ARMS:	
ELBOWS:	
WRISTS:	
HANDS/FINGERS:	
HIPS:	
THIGHS:	
KNEE:	
LOWER LEG (shin, calves)	
ANKLES:	
FEET/TOES:	

Is there anything else we should be aware of regarding your student's health? _____

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that I am hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG or ECHO) and/or cardio stress test. If any of the tests are performed on your student, please include a copy with this form:

Parent/Guardian Signature: _____ Date: _____



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STUDENT HEALTH RECORD/PHYSICIANS REPORT

*To be completed by Physician

STUDENT NAME: _____

DATE OF EXAM: _____

Sunaskeo is dedicated to the health and safety of our athletes. For that reason we have adopted the American Heart Association's 12 Point Recommendations for Pre-Participation Screening of High School and college athletes. **If any of the following criteria are present, then all of the following items are required prior to participating at Sunaskeo: 1) EKG 2) echocardiogram 3) letter of clearance from a cardiologist.** Results of each of these tests and a letter of clearance from the cardiologist must be on file prior to the student's arrival.

CARDIAC EVALUATION:

Please check each box, make any notations for 'yes' answers and your signature is required.

PERSONAL MEDICAL HISTORY	YES	NO	COMMENTS
Exertional chest pain/discomfort			
Syncope/near syncope			
Excessive exertional and otherwise unexplained dyspnea/fatigue associated with exercise			
Prior recognition of heart murmur			
Elevated Blood Pressure			
FAMILY MEDICAL HISTORY			
Premature death (sudden or otherwise) related to heart disease in relatives			
Disability from heart disease in close relative younger than 50 years old			
Specific knowledge of hypertrophic or dilated cardiomyopathy, ion channelopathies such as long QT syndrome, Marfan Syndrome or clinically important arrhythmias			
PHYSICAL EXAMINATION:			
Heart Murmur			
Aortic Coarctation noted on Femoral Pulse Exam			
Physical stigmata of Marfan Syndrome			
Abnormal Brachial artery blood pressure (sitting position)			

Notes: _____

Remember any 'yes' answers need to result in: 1) EKG 2) echocardiogram 3) letter of clearance from a cardiologist.

STUDENT HEALTH RECORD/PHYSICIANS REPORT

*To be completed by Physician

STUDENT'S NAME: _____

SCREENING TESTS

VISION: _____	DATE: _____	Wears Glasses: YES NO	
		Wears Contacts: YES NO	
	Right _____ Left _____	With Correction	
DISTANCE ACUITY	Right _____ Left _____	Without Correction	

PHYSICIAN'S EXAMINATION: Date of Exam: _____

HEIGHT: _____	BP: _____	MEDICATIONS: _____ _____
WEIGHT: _____	PULSE: _____	REASONS TAKEN: _____ _____

Describe any variations from the norm **N = NORMAL** **AB= ABNORMAL**

Teeth: _____	Extremities: _____	Other: _____
Glands: _____	Eyes: _____	Men- ses: _____
Lungs: _____	Ears: _____	Chest X-ray: _____
Skin: _____	Abdomen: _____	NOTE: CXR must be done if stu dent has had BCG or +
Heart: _____	GI System: _____	
Scalp: _____	Vital Signs: _____	
Explain Abnormal Findings: _____		

This student is cleared to participate as follows: (CIRCLE ONE)

UNRESTRICTED CLEARANCE OR RESTRICTED CLEARANCE WITH LIMITATIONS BELOW

Specify Limitations: _____

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STUDENT'S NAME: _____

Physician: Please provide any additional information you believe should be brought to the attention of Sunaskeo to enable the student too participate in athletics or to provide for the student's well-being:

ADDITIONAL COMMENTS: _____

I understand that Sunaskeo programs do include vigorous physical activities and exertion, which will occur in a hot and humid environment, such as those in North Texas and Florida.

I have discussed the "12 Point" cardiac evaluation with the student and parents/ legal guardian, performed a physical examination and believe he/she is physically able to participate in athletic and sports activities as described.

Examiner's Name: _____

Examiner's Signature: _____ Date: _____

Address: _____

Phone: _____



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STUDENT HEALTH RECORD/PHYSICIANS REPORT

**** THIS FORM IS DUE ANNUALLY ****

Person Completing Vaccination Form: _____

Date: _____ Student's Name: _____

TUBERCULOSIS SCREENING (MANTOUX PPD SKIN TEST)

Have you been experiencing any of the following signs/symptoms that may be associated with TB?

- | | | |
|---|---------|--------|
| 1) Persistent Cough (> 3 weeks) | ___ Yes | ___ No |
| 2) Coughing up Blood | ___ Yes | ___ No |
| 3) Unexplained Weight Loss | ___ Yes | ___ No |
| 4) Loss of Appetite | ___ Yes | ___ No |
| 5) Fever/Chills | ___ Yes | ___ No |
| 6) Night Sweats | ___ Yes | ___ No |
| 7) Tire Easily | ___ Yes | ___ No |
| 8) Have you ever had positive TB skin Test? | ___ Yes | ___ No |
| 9) Have you ever taken medication prophylactically
because you were exposed to TB? | ___ Yes | ___ No |
| 10) Females: Are you pregnant? | ___ Yes | ___ No |

Anyone with a YES response will require a TB test or chest x-ray.

Date of test: _____	Date read: _____	2nd Test Required: ___ YES ___ NO
Site: _____	Results in MM: _____	Date of 2nd Test: _____
By: _____	By: _____	Site: _____
Manufacturer: _____	By: _____	
Lot #: _____	Results in MM: _____	Expiration Date: _____

Meningococcal Vaccine

I understand the meningococcal (meningitis) vaccine is strongly recommended by the Centers for Disease Control in Atlanta for students living in dorms. It is also recommended for children 11 and 12 years old and teens entering high school. Sunaskeo will not transport students to receive the vaccine. Circle the appropriate response:

- I wish to decline the vaccine for my student. I understand and accept the risks of Meningococcal meningitis, which can cause very severe illness and death.
- I will take my student to his/her local physician or Health Dept. to obtain the vaccine and will provide Sunaskeo with proof of vaccination.
- My student already received the meningococcal vaccine on date: _____ and I will provide proof of vaccination to Sunaskeo.

Parent/Guardian Signature: _____ Date: _____



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