

**HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS)  
for FORT BUCHANAN  
ENROLLMENT, RENEWAL & SPORTS PHYSICALS**

Revised 28 AUG 15

**DATA REQUIRED BY THE PRIVACY ACT OF 1994**

**PRINCIPAL PURPOSE:** : Information is used by DOD 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: Medical History (Filled out by parent / guardian)**

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

**CHILD HEALTH INFORMATION**

Name of Child	Birth Date	Sex	Male	Female
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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			26. Other (please list below)		

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 Inches	Weight LBS:
BP: P:	/	Visual Acuity Right / Left /	Tested with / without glasses
	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>N / A</b>
<b>COMMENTS</b>			
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  
 Additional comments                       Restrictions

Sports Physical is valid for 1 year from date indicated below

## PART C Sports Physical is valid for 1 year from date indicated below

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 or DoDEA-Americas programs?     Yes    No

Date                      Licensed Health Care Professional Stamp                      Licensed Health Care Professional Signature

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

### HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Year 3 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	