

Will be known as:



Kevin R. Hilton, MD/Orthopedic
Lodi Health Physical Therapy

Pre-Sports/Athletic Participation Form

Part 1: (To be completed by student and parents/guardian)

Name: _____ Grade: _____
Address: _____
City: _____ Zip: _____ Phone: _____
Age: _____ Birth Date: _____ Gender: _____

Year in School: **Fr So Jr Sr**
Sports – Circle all that apply:
Badminton Soccer Volley ball
Baseball Softball Water Polo
Basketball Swimming / Diving Wrestling
Cross Country Tennis Golf
Football Track and Field

Doctor's Name: _____ Doctor's Phone: _____
Health Insurance: _____

Health History:

Date of Last known Tetanus Shot: _____
Current Medications: _____
Any Allergies (medication/Food/Insects, etc.) and Reactions: _____
Please Circle (Must be Completed **PRIOR** to the Exam)

Is there a history of:

Hospitalizations?	Y/N	Knee injury?	Y/N
Surgery other than removal of tonsils?	Y/N	Shoulder or elbow injury?	Y/N
Missing organs (eye, kidney, testicle)?	Y/N	Ankle injury?	Y/N
Asthma	Y/N	Dislocation of a joint?	Y/N
Chest pain or severe shortness of breath with exercise?	Y/N	Catching or locking of joint?	Y/N
Problems with blood pressure or heart?	Y/N	Broken bones/fractures?	Y/N
Dizziness or fainting with exercise?	Y/N	Ulcers or hernias?	Y/N
Skin problems?	Y/N	Stingers/burners?	Y/N
Severe or frequent headaches?	Y/N	Menstrual cycle	Y/N
Concussion of loss or consciousness	Y/N	Last Menstrual Period: _____	
Heat exhaustion, heat stroke or other	Y/N	Has any family member died suddenly at less than 40 years of age of causes other than an accident?	Y/N
Problems with heat?	Y/N		
Mono, hepatitis, hemophilia?	Y/N		
Diabetes?	Y/N		
Seizures/Convulsions?	Y/N	Has any family member had a heart attack at less than 55 years of age?	Y/N
Neck or Back injury?	Y/N		

PLEASE EXPLAIN ANY "YES" (Y) ANSWERED ABOVE:

Parent's or Guardian's Acknowledgement: I have reviewed and agree with the information presented on this form. I also understand that this examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal physician. There is no reason why the above named student should not participate and represent his or her school in supervised athletic activities.

PRINT Name of Parent /Guardian Signature of Parent /Guardian
() _____ / () _____ / _____

