



ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

Must be completed **every school year** by the athlete and parent prior to any try-out, practice, or athletic contest.

THIS FORM MUST BE STORED IN A SECURE

ATHLETE INFORMATION

Athlete Name: _____ Date of Exam: _____

Sport(s): _____

Birth date: _____ Age: _____ Grade in school _____ Gender: _____ School year: _____

Athlete Cell Phone No. (_____) _____ Athlete Address: _____

EXAMINATION: TO BE FILLED OUT BY PHYSICIAN ONLY

Height: _____ Weight: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Pulse: _____ BP: _____ / _____ % Body Fat (opt) _____
Vision: Left _____ / _____ Right _____ / _____ Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pupils: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal
Immunizations: Tetanus _____ MMR _____ Hep B _____ Chickenpox _____	

GENERAL MEDICAL (please initial)			MUSCULOSKELETAL (please initial)		
	Normal	Abnormal Findings		Normal	Abnormal Findings
Appearance (Marfan stigmata)			Neck		
Eyes/Ears/Nose/Throat (Pupils Equal, Hearing)			Back		
Lymph Nodes			Shoulder/ Arm		
Heart (murmurs)			Elbow/ Forearm		
Pulses (Simultaneous femoral and radial pulses)			Wrist/ Hand/ Fingers		
Lungs			Hip/ Thigh		
Abdomen			Knee		
Skin (HSV, MRSA, tinea corporis)			Leg/ Ankle		
Neurological			Foot/ Toes		
Genitourinary (males only)			Functional (Duck walk, single leg hop)		

ATHLETIC PARTICIPATION RECOMMENDATIONS *(Physician MUST select one item listed below)*

- _____ **FULL & UNLIMITED PARTICIPATION**
- _____ **LIMITED PARTICIPATION**—May NOT participate in the following _____
- _____ **CLEARED PENDING**—Documented follow up of: _____
- _____ **NOT CLEARED FOR ATHLETIC PARTICIPATION**

Physician's Comments: _____

By signing this form, I acknowledge that I am board certified in a medical specialty, and in addition, I am current in my maintenance of certification.

Medical Provider: _____

(Please print)

Medical Signature: _____ Date: _____

Providers Address: _____

Providers Phone #: _____

MD DO NP PA

DC: The above named athlete is not currently prescribed medication.

DC: Student is taking medication and I have consulted with the prescribing Physician

IF THIS FORM IS NOT FULLY COMPLETED INCLUDING DOCTOR ADDRESS AND NUMBER, IT WILL NOT BE ACCEPTED



ATHLETIC PRE-PARTICIPATION EXAM AND MEDICAL HISTORY

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Athlete Name: _____ **Date of Birth** _____

MEDICAL HISTORY

Medicines: Please list all of the prescription and over-the-counter medicine and supplements (herbal and nutritional) that you are currently taking _____

Allergies: Do you have any allergies? Yes No If yes, please identify specific allergy. _____

Medicines _____ Pollens _____ Food _____ Stinging Insects _____

ANY "YES" RESPONSES MUST BE EXPLAINED IN FULL AFTER EACH QUESTION IN THE SPACE

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?			Do you cough, wheeze or have difficulty breathing during or after exercise?		
Do you have any ongoing medical conditions? If so please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____			Have you ever used an inhaler or taken asthma medication?		
Have you ever spent the night in the hospital?			Is there anyone in your family who has asthma?		
Have you ever had surgery?			Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	Do you have groin pain or a painful bulge or hernia in the groin area?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?			Have you had infectious mononucleosis (mono) within the last month?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			Do you have any rashes, pressure sores, or other skin problems?		
Does your heart ever race or skip beats (irregular beats) during exercise?			Have you had a herpes or MRSA skin infection?		
Has a doctor ever told you that you have any heart problems? If so check all that Apply: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> A heart murmur <input type="checkbox"/> A heart infection <input type="checkbox"/> Other: _____			Do you have a history of seizure disorder?		
Has a doctor ever ordered a test for your heart? (e.g. ECG/EKG, Echocardiogram)?			Have you had any problems with your eyes or vision?		
Do you get light headed or feel more short of breath than expected during exercise?			Have you had any eye injuries?		
Have you ever had an unexplained seizure?			Do you wear glasses or contact lenses?		
Do you get more tired or short of breath more quickly than your friends during exercise?			Do you wear protective eye wear such as goggles, or a face shield?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	Do you worry about your weight?		
Has any family member or relative died of a heart problem or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?			Are you trying to or has anyone recommended that you gain or lose weight?		
Does anyone in your family have hypertrophic cardiomyopathy, Long QT syndrome, Short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?			Are you on a special diet or do you avoid certain types of foods?		
Does anyone in your family have a heart problem, pacemaker, or implanted Defibrillator?			Have you ever had an eating disorder?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			HEAT ILLNESS QUESTIONS	Yes	No
BONE AND JOINT QUESTIONS	Yes	No	Have you ever become ill while exercising in the heat?		
Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?			Do you get frequent muscle cramps when exercising?		
Have you ever had any broken, fractured or dislocated bones?			Do you or someone in your family have sickle cell trait or disease?		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?			HEAD AND NECK HEALTH QUESTIONS	Yes	No
Have you ever had a stress fracture?			Do you have headaches with exercise?		
Have you ever been told that you have or have you had an x-ray for a neck instability or atlantoaxial instability (down syndrome or dwarfism)?			Have you ever had a head injury or concussion?		
Do you regularly use a brace, orthotics, or other assistive devices?			Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
Do you have a bone, muscle, or joint injury that bothers you?			Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Do any of your joints become painful, swollen, feel warm or look red?			Have you ever been unable to move your arms or legs after being hit or falling?		
Do you have any history of juvenile arthritis, or connective tissue disease?			FEMALES ONLY		
Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? <i>Specify below if yes</i>			When was your first menstrual period (age when started)?		
If yes, check the appropriate box and explain below:			When was your most recent menstrual period?		
<input type="checkbox"/> Head _____ <input type="checkbox"/> Neck _____			How much time do you usually have from the start of one period to the start of another?		
<input type="checkbox"/> Back _____ <input type="checkbox"/> Shoulder _____			How many periods have you had in the last year?		
<input type="checkbox"/> Arm _____ <input type="checkbox"/> Elbow _____			What was the longest time between periods in the last year?		
<input type="checkbox"/> Finger _____ <input type="checkbox"/> Wrist _____					
<input type="checkbox"/> Hand _____ <input type="checkbox"/> Shin/Calf _____					
<input type="checkbox"/> Thigh _____ <input type="checkbox"/> Knee _____					
<input type="checkbox"/> Hip _____ <input type="checkbox"/> Ankle _____					
<input type="checkbox"/> Foot _____					

Parent Signature: _____ **Date:** _____