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 LOCATION

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: __________ ▢ Male ▢ Female | Pulse: _______ BP: _____/_____ % Body Fat (opt) _____

Vision: Left_______/_______Right_______/_______ Corrected: ▢ Yes ▢ No Pupils: ▢ Equal ▢ Unequal

Immunizations: Tetanus ___________ MMR _____________ Hep B _____________ Chickenpox____________

GENERAL MEDICAL (please initial)	Normal	Abnormal Findings	MUSCULOSKELETAL (please initial)	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)

❑ MD ❑ DO ❑ NP ❑ PA

Medical Signature: ______________________ Date: _______

Providers Address: ____________________________________

____

Providers Phone #: ______________________________

❑ 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

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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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ 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: **☐ High Blood Pressure ☐ High Cholesterol ☐ Kawasaki Disease** **☐ A heart murmur ☐ A heart infection ☐ 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 of 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? *Specify below if yes*				When was your first menstrual period (age when started)?		
If yes, check the appropriate box and explain below: ☐ Head ____________________☐ Neck ________________________ ☐ Back ____________________ ☐ Shoulder ______________________ ☐ Arm ____________________ ☐ Elbow _______________________ ☐ Finger ___________________ ☐ Wrist _______________________ ☐Hand ____________________ ☐ Shin/Calf _____________________ ☐Thigh ____________________ ☐ Knee ________________________ ☐Hip _____________________☐Ankle ________________________ ☐Foot ____				When was your most recent menstrual period? How much time do you usually have from the start of one period to the start of another? How many periods have you had in the last year? What was the longest time between periods in the last year?		

Parent Signature: ______________________________ Date: ____________