ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Medical History – Parent/guardian please fill out prior to examination

Name: ______________________ **Age:** ________ **Grade:** ________ **DOB:** ________
(Please Print) Last First MI

Explain "yes" answers below

Question	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have an ongoing medical condition (like diabetes or asthma)?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever become dizzy or passed out **DURING or AFTER** exercise?		
6. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?		
7. Do you get more tired than your friends do during exercise?		
9. Has a doctor ever told you that you have: ☐High Blood Pressure ☐Heart Murmur ☐Heart Infection ☐High Cholesterol (Check all that apply)		
10. Has a doctor ever ordered a test for your heart?(for example ECG, echocardiogram)		
11. Has anyone in your family ever died for no apparent reason?		
12. Does any one in your family have a heart problem?		
13. Has a family member or relative died of heart problems or sudden death before the age of 50?		
14. Have any of your relatives ever had any one of the following conditions? Hypertrophic cardiomyopathy, dilated cardiomyopathy, Marfan's syndrome or Long QT Syndrome or a significant heart arrhythmia?		
15. Have you ever had racing of your heart or skipped heartbeats?		
16. Have you ever spent the night in a hospital?		
17. Have you ever had surgery?		
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? If yes circle affected area below:		
19. Have you had any broken or fractured bones or dislocated joints? If yes circle affected area below:		
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes circle affected are below:		

Head	Neck	Shoulder	Upper arm	Elbow	Calf or shin	Hand	Chest
Upper back	Lower Back	Forearm	Thigh	Knee	Hip	Ankle	Foot Toes

Question	Yes	No
21. Have you ever had a stress fracture?		
22. Have you ever been told that you have or have had an x-ray for atlantoaxial (neck) instability?		
23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Is there anyone in your family with asthma?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Were you born without or are you missing a kidney, an eye or testicle, or any other organ?		
28. Have you had a severe viral infection such as infectious mononucleosis (mono) or myocarditis in the last month?		
29. Do you have any rashes, pressure sores or other skin problems?		
30. Have you had a herpes infection?		
31. Have you had a head injury or concussion?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Have you ever had a seizure?		
34. Do you have headaches with exercise?		
35. Have you ever had numbness or tingling or weakness in your arms, or legs?		
36. Have you ever been unable to move your arms or legs after being hit or fallen?		
37. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear such as goggles or a face shield?		
42. Are you unhappy with your weight?		
43. Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Do you have concerns that you would like to discuss with the doctor/health care provider?		
FEMALES ONLY:		
47. Have you ever had a menstrual period?		
48. How old were you when you had your first menstrual period?		
49. How many periods have you had in the last 12 months?		

Explain "Yes" answers here (*use the back of the form if necessary):*

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Concussion Management

A concussion is a disturbance in the function of the brain that can be caused by a blow to the body or head and may occur in any sport or activity. Effects of a concussion may include variety o f symptoms (headache, nausea, dizziness, memory loss, balance problem) with or without a loss of consciousness.

I/WE HEREBY CERTIFY THAT THE ABOVE INFORMATION IS VALID AND CORRECT TO THE BEST OF MY /OUR KNOWLEDGE. FURTHER, I/WEUNDERSTAND THERE IS A CONCUSSION MANAGEMENT PROTOCAL ESTABLISHED THAT INLCUDES CARE AND RETURN TO PLAY CRITERIA.

________________________	__________	________________________	__________
Student-Athlete Signature	**Date**	**Parent or Court Appointed legal Guardian Signature**	**Date**

Sport Concussion
Information Paper

A concussion is a disturbance in the function of the brain caused by a blow to the body or head, occurring in any sport or activity
Signs to watch for:

- Headache
- Nausia
- Dizziness
- Problems with Memory
- Balance problems

Problems could arise over the first 24-48 hours. You should not be left alone and must go to a hospital at once if you:

- Have a headache that gets worse
- Are very drowsy or can't be awakened (woken up)
- Can't recognize people or places
- Have repeated vomiting
- Behave unusually or seem confused, are very irritable
- Have seizures (arms and legs jerk uncontrollably)
- Are unsteady on your feet; have slurred speech

Remember: it is better to be safe: Consult your doctor after a suspected concussion.

Remember, concussion should be suspected in the presence of ANY ONE or more of the following:

- Symptoms (such as a head ache), or
- Signs (such as loss of consciousness), or
- Memory problems

Any athlete with a suspected concussion should be monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle.

Return To Play:
Athletes must be signs/symptoms free and have medical release from a licensed health care professional to return to athletic participation. When returning athletes to play, they will follow a stepwise symptom-limited program, with stages of progression. If the athlete exhibits any sign and/or symptom of a concussion, the athlete will be out of activities the rest of the day and follow the return to play protocol. (No matter the grade of concussion)
For a copy of the return to play protocol, Carlsbad Athletic Department will have them on file.

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Athlete's Name ____ Sex ___________ Age __________

DOB ______________ Height____________ Weight___________ Pulse__________ BP____/____/_____

Vision R 20/_____ L 20/_____ Corrected:____Yes ____No Pupils:________Equal ________Unequal

As a minimum requirement this **PHYSICAL EXAMINATION FORM must be completed** yearly beginning in Junior High and continuing through High School for each year that the said student participates in interscholastic activities.

MEDICAL	**NORMAL** (Circle One)		**ABNORMAL Findings/Comments**
Appearance	YES	NO	
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph Nodes	YES	NO	
Heart *(Auscultation should be done supine and standing)*	YES	NO	
Murmurs	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: Assessment (incl. Liver, spleen)	YES	NO	
Genitourinary (Males only)	YES	NO	
Skin	YES	NO	
MUSCULOSKELETAL			
Neck	YES	NO	
Back	YES	NO	
Shoulder/Arm	YES	NO	
Elbow/Forearm	YES	NO	
Wrist/Hand/Fingers	YES	NO	
Hip/Thigh	YES	NO	
Knee	YES	NO	
Leg/Ankle	YES	NO	
Foot Toes	YES	NO	

NOTES:____
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ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Athlete's Name ____ Date of Birth ___________________

The following information must be completed and signed by a Licensed Medical Physician, Licensed Doctor of Osteopathy, Licensed Physician's Assistant, Licensed Nurse Practitioner, or a Licensed Chiropractor.

Student/Athlete **MAY** participate in the following types of sports (check **ALL** that apply):

_____ **ALL FORMS OF SPORTS** _____ Contact/Collision _____ Limited Contact

_____ Non-Contact/Strenuous _____ Non-Contact/Non-Strenuous

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

CLEARANCE:

________ Student cleared for participation
________ Student cleared for participation pending evaluation/rehabilitation for: ____________________________
________ Student **NOT** cleared for participation

Recommendations:

I hereby verify that I have reviewed this student-athlete's medical history, given the student/athlete a physical evaluation and discussed the results with the student/athlete.

Signature of Examining Physician ______________________________________ Date _________________