PRE-PARTICIPATION HISTORY FORM

⇩ COMPLETE ENTIRE FORM & SIGN ⇩

Name: ______________________ Sex: ☐M ☐F Date of Birth: __________ Age: ____
Grade: ________ School: ______________________ Sport(s): ______________________
Address: ______________________ Phone: ______________________
Personal Physician: ______________________ Date of Last Exam: ______________________
Allergies: ______________________ Medication List: ______________________
In Case of Emergency, Contact: Name: ______________________ Relationship: ______________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Answer all questions that apply by checking Yes or No

	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 non-prescription (over-the-counter) medicines or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8. Does your heart race or skip beats during exercise?		
9. Has a doctor ever told you that you have (check all that apply) ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (example: ECG, echocardiogram)		
11. Has anyone in your family died for no apparent reason?		
12. Does anyone in your family have a heart problem?		
13. Has any family member or relative died of heart problems or of sudden death before age 50?		
14. Does anyone in your family have Marfan syndrome?		
15. Have you ever spent the night in a hospital?		
16. Have you ever had surgery?		
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, which caused you to miss a practice or game? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
19. 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 below: Head / Neck / Shoulder / Upper Arm / Elbow / Forearm / Hand/ Fingers / Chest / Upper Back / Lower Back / Hip / Thigh / Knee / Calf/ Shin / Ankle / Foot/ Toes		
20. Have you ever had a stress fracture?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		
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 who has 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, a testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last 6 weeks?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you had a herpes skin infection?		
31. Have you ever 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, tingling, or weakness in your arms or legs after being hit or falling?		
36. Have you ever been unable to move your arms or legs after being hit or falling?		
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 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 happy 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 any concerns that you would like to discuss with a doctor?		
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?		
50. Are you, or could you possibly be, pregnant?		

Explain "Yes" answers here: ____

To the best of my knowledge, I have given true and accurate information and I have answered all questions completely. I understand this evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. I hereby grant permission for this physical screening evaluation and I understand no evaluation will be done unless all questions are answered and this form is signed.

Printed Name of Parent/Guardian ______________________

Signature of Patient's Parent/Guardian ______________________
(Required if Patient Less Than 18 Years Old)

Date ____________

PRE-PARTICIPATION PHYSICAL FORM

⇩ COMPLETE TOP TWO LINES ONLY ⇩

Name: ______________________ Sex: ☐M ☐F Date of Birth: __________ Age: _____

Grade: ________ School: ______________________ Sport(s): ______________________

Height: ________ Weight: ________ Vision: R 20/___ L 20/___ Corrected ☐Y ☐N

Pulse: ________ BP: ___/___ (If > 140/90 Re-Check: ___/___ & ___/___)

Tobacco: ☐Y ☐N ________ ETOH: ☐Y ☐N ________ Drugs: ☐Y ☐N ________

☐ History Form Received & Reviewed

MEDICAL EXAM	NORMAL	ABNORMAL FINDINGS	DEFERRED
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Murmurs	Absent	Grade:	
Pulses			
Lungs			
Abdomen			
Genitourinary (Males Only)			
Skin			

MUSCULOSKELETAL EXAM	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Consider further evaluation if arm span greater than height, pectus excavtum or pectus carvatum is present.

Clearance Status:

_____ Cleared to Participate

_____ Cleared After Follow-up Physician for ______________
Clearance letter from physician follow up should be attached to this form.

_____ Cleared After Follow-up School Nurse for ______________
School nurse should document follow up clearance and co-sign accordingly.

_____ Not Cleared for Following Reason(s): ______________

Evaluation Not Done Due To:

_____ Incomplete Pre-Participation History Form

_____ Incomplete Parent/Guardian Signature

Additional Clearance Notes:

____

_____ Flag for Athletic Trainer to Review

Additional Notes/Comments: ______________________________

______________________________ Provider Signature

______________ Date