NAME OF SCHOOL YOU
WILL ATTEND NEXT YEAR

_____

School Sports Pre-Participation Examination

NAME: _____ BIRTHDATE: _____/_____/_____

ADDRESS: _____PHONE: (_____)_____

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your ability.
Physician: Please review with the athlete details of any positive answers.

YES	NO	DON'T KNOW	
_____	_____	_____	1. Has anyone in the athlete's family died suddenly before the age of 50 years?
_____	_____	_____	2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?
_____	_____	_____	3. Does the athlete have asthma (wheezing), hay fever, or coughing spells during or after exercise?
_____	_____	_____	4. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
_____	_____	_____	5. Does the athlete have a history of a concussion (getting knocked out) or seizures?
_____	_____	_____	6. Has the athlete ever suffered a heat-related illness (heat stroke)?
_____	_____	_____	7. Does the athlete have a chronic illness or see a physician regularly for any particular problem?
_____	_____	_____	8. Does the athlete take any prescribed medicine, herbs or nutritional supplements?
_____	_____	_____	9. Is the athlete allergic to any medications or bee stings?
_____	_____	_____	10. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc)?
_____	_____	_____	11. Has the athlete ever had prior limitation from sports participation?
_____	_____	_____	12. Has the athlete had any episodes of shortness of breath, palpitations, history of rheumatic fever or unusual fatigability?
_____	_____	_____	13. Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?
_____	_____	_____	14. Is there a history of young people in the athlete's family who have had congenital or other heart disease: Cardiomyopathy, abnormal heart rhythms, Long QT or Marfan syndrome? (You may write "I don't understand these terms" and initial this item, if appropriate.)
_____	_____	_____	15. Has the athlete ever been hospitalized overnight or had surgery?
_____	_____	_____	16. Does the athlete lose weight regularly to meet the requirements for your sport?
_____	_____	_____	17. Does the athlete have anything he or she wants to discuss with the physician?
_____	_____	_____	18. Does the athlete cough, wheeze, or have trouble breathing during or after activity?
_____	_____	_____	19. Does the athlete have asthma?
_____	_____	_____	20. FEMALES ONLY: a. When was your first menstrual period? _____ b. When was your most recent menstrual period? _____ c. What was the longest time between menstrual periods in the last year? _____

(Explain any YES answers on back.)

Parent/Guardian's Statement:

I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give permission for my child to participate in sports/activities.

I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a licensed athletic trainer, coach, or medical practitioner.

I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment.

I hereby authorize release of these examination results to my child's school.

Signed: _____ Date: _____

NAME OF SCHOOL YOU WILL ATTEND NEXT YEAR:

_____

School Sports Pre-Participation Examination

NAME:_____ BIRTHDATE: _____ /_____ /_____

Height: _____ Weight: _____ Pulse: _____ BP: _____

Rhythm: Regular _____ Irregular _____

Vision: R 20/___ L 20/___ Corrected: Y N Pupils: Equal ____ Unequal ____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart: Pericardial Activity			
Pulses: Brachial/Femoral			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

___ Cleared

___ Cleared after completing evaluation/rehabilitation for: _____

___ Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type): _____ Date: ___ /___ /___

Address: _____ Phone: _____

Signature of Physician: _____