

PRE-PARTICIPATION HISTORY & PHYSICAL EXAM

Name: _____ Sex: F M Age: _____ Date of Birth: _____
 Grade: _____ School: _____ Sport(s) Please list ALL: _____
 Address: _____ Phone: _____
 Personal Physician: _____ None
 Emergency Contact: Name: _____ Relationship: _____ Phone(s): _____

Attention parent or guardian and athlete: answers to the following questions are very important! Please take the time to read through the questions and answer to the best of your knowledge.

General Medical History:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you have asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have diabetes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have sickle cell trait?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any other major medical problem?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been hospitalized or had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you cough, wheeze or have trouble breathing with exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use an inhaler?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a single organ (testicle or kidney)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or improve performance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any allergies (seasonal, insects, food, or medicines)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a rash or hives develop during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any skin problems other than acne?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung," or a concussion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had numbness or tingling in your arms, hands, legs, or feet?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a stinger, burner, or pinched nerve?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever become ill from exercising in the heat?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had mononucleosis or any significant illness in the last 60 days?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have trouble with your eyes/vision/wear glasses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have trouble with your hearing/wear hearing aid(s)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you want to weigh more or less than you do now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you lose weight regularly to meet weight requirements for your sport or other reason?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel stressed out, tired, or depressed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are there any other issues you would like to discuss with the doctor?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are your immunizations up to date?..... | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

- | | | |
|--|--------------------------|--------------------------|
| 27. Are your periods regular (every month)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Are your periods heavy?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here (use back/page 2 if needed): _____

Cardiac History:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever passed out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had chest pain or chest pressure during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you tire easily or more quickly than your friends during exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had racing of your heart or skipped heartbeats?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been told you had a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been told you had an enlarged or weak heart?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has any member of your family: | | |
| • died of heart problems or sudden death before age 50?... | <input type="checkbox"/> | <input type="checkbox"/> |
| • been told they had a serious heart problem before age 50?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • been told they had Marfan's Syndrome?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a physician ever denied or restricted your participation in sports?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here: _____

Orthopaedic History:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever broken or fractured any bones?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever subluxed or dislocated any joint?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any other problems related to your: | | |
| • neck, spine, or back?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • shoulders?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • elbows?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • wrists, hands, or fingers?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • hips?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • knees?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • ankles, feet, or toes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • other?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here (put date of injury if known): _____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Vision: L20/____ R20/____ Both _____ Corrected: Y N BMI _____ (Wt. in kg/hgt. in meters squared)

Height _____ Weight _____ Pulse _____ B/P (R arm) _____

Medical	Normal	Abnormal Findings
Appearance/Emotional Affect		
Head/Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart (squatting to standing and supine)		
Pulses (including femoral)		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Musculoskeletal	Normal	Abnormal Findings
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

May Participate in all sports, EXCEPT those listed below:

May Participate after completing evaluation/rehabilitation for: _____

May Not Participate – Reason: _____

Recommendations: _____

Signature of M.D.: _____ **Date of Exam:** _____

Printed Name: _____ **Office Stamp**

Phone Number: _____

Extra Space for "YES" answers from the front: _____

Developed 2003-2004 by the Richland County (South Carolina) School District One Task Force On Athletic Health Issues following a review of related information from the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, the South Carolina High School League and the National Federation of State High School Associations. Revised 011807 by the SCMA Medical Apects of Sports Committee.

EMERGENCY CONTACT – MEDICAL AUTHORIZATION FORM

Student Name: First Last MI Sport(s)

Date of Birth: (m/d/y) Grade in School Telephone Number/Contact Info.

Parent/Guardian Name: First Last MI Emergency Contact Name

Permanent Address City Zip Emergency Contact Phone #

Primary Insurance Company Policy/Claim Number

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

(Part I or II Must Be Completed)

Part I – To Grant Consent

In the event reasonable attempts to contact me or another parent/guardian using the information provided above have been unsuccessful, I hereby give consent for (1) The administration of any treatment deemed necessary by Dr.

(Preferred Physician) or Dr. (Preferred Dentist), or in the event the designated preferred practitioner is not available, by another licensed physician, Certified Athletic Trainer or dentist; and (2) the transfer of the child to (Preferred Hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment(s) to which a physician should be alerted:

Date

Signature of Parent or Guardian

(Do Not Complete Part II If You Completed Part I)

Part II – Refusal to Consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

Date

Signature of Parent or Guardian

Emergency Information and Parent Consent Form

ATHLETIC DEPARTMENT EMERGENCY INFORMATION AND PARENT CONSENT

Name: _____ Birthdate: _____ Age: _____

Parent's Name: _____ Home Phone: _____

Address: _____ City: _____ Grade: _____

Day Phone of Parents: Father _____ Mother _____

In an emergency, if the parents cannot be reached, notify:

_____ Phone: _____

Family Doctor: _____ Phone: _____

Known Allergies: _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the above-named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

Permission is also granted to the Certified Athletic Trainer to provide the needed emergency treatment prior to the student's admission to the medial facilities.

Parent Signature: _____ Date: _____