SPRINGVILLE HIGH SCHOOL

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*

Name: _____ Date of Exam: _____

Sport(s):_____

Birth date: _____ Age: _____ Grade: _____ Gender: _____

Family Doctor: _____ Phone No. (_____)_____

PHYSICAL

Height _____ Weight _____ Pulse_____ BP _____ % Body Fat (opt)_____

Vision: Left _____/20 Right _____/20 Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

Immunizations: Tetanus _____ MMR _____ Hep B _____ Chickenpox_____

GENERAL MEDICAL	Normal	Abnormal Findings	Initial
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

FEMALES ONLY:

When was your first menstrual period (age when started)? _____

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? _____

ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **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: _____

_____

_____

_____

Physician's Name: _____
(please print)

Physician Signature: _____ Date: _____

Doctor's Office Address Information

Phone (_____) _____

MEDICAL HISTORY

Any "yes" responses must be explained in full after each question in the space provided

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?		
2. Do you have an ongoing or chronic illness?		
3. Have you been hospitalized overnight in the past year?		
4. Have you ever had surgery?		
5. Have you ever passed out during or after exercise?		
6. Do you get tired more quickly than your friends do during exercise?		
7. Have you ever had racing of your heart or skipped heartbeats?		
8. Have you ever had chest pain during or after exercise?		
9. Have you had high blood pressure or high cholesterol?		
10. Have you ever been told you have a heart murmur?		
11. Has any family member or relative died of heart problems or sudden unexpected death before age 50?		
12. Has any family member been diagnosed with enlarged heart, QT syndrome, or other ion channelpathy, Marfan's Syndrome, or abnormal heart rhythm?		
13. Have you ever been diagnosed with a severe viral infection (i.e. myocarditis or mononucleosis)?		
14. Has a physician ever denied or restricted your participation in sports for any reason?		
15. Do you have frequent or severe headaches?		
16. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
17. Have you ever had a stinger, burner, or pinched nerve?		
18. Have you ever had a head injury or concussion?		
19. Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times? _____ Last occurrence? _____ PLEASE EXPLAIN:		
20. Have you ever had a seizure?		
21. Are you missing any paired organ?		
22. Are you under a doctor's care right now?		
23. Are you currently taking any prescription or non-prescription medication or pills or using an inhaler?		
24. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
25, Do you have any allergies (i.e. pollen, medicine, food, insects, etc.)?		
26. Have you ever been dizzy during or after exercise?		
27. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, etc.)?		
28. Have you ever had a rash or hives develop during or after exercise?		
29. Have you ever become ill from exercising in the heat?		
30. Have you had any problems with your eyes or vision?		
31. Have you ever gotten unexpectedly short of breath with exercise?		
32. Do you have asthma?		
33. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, orthotics, hearing aid, etc.)?		
34. Do you want to weigh more or less than you do now?		
35. Do you lose weight regularly to meet weight requirements for your sport?		
36. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?		
37. Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? If yes, check the appropriate box and explain below		

☐ Head _____	☐ Elbow _____	☐ Thigh _____
☐ Neck _____	☐ Finger _____	☐ Knee _____
☐ Back _____	☐ Wrist _____	☐ Hip _____
☐ Shoulder _____	☐ Hand _____	☐ Ankle _____
☐ Arm _____	☐ Shin/Calf _____	☐ Foot _____