

# Preparticipation Sports Examination

## Medical History

Please answer the following questions by circling yes or no. If you answer yes, please explain at the bottom of the form and on back if necessary.

- |   |     |           |
|---|-----|-----------|
| 1. Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by a doctor?                 | Yes | No        |
| 2. Do you take any medication of any type?  | Yes | No        |
| 3. Have you ever had a severe allergic reaction to anything?  | Yes | No        |
| 4. Have you ever had allergic problems such as hay fever, asthma or eczema?   | Yes | No        |
| 5. Do you have difficult breathing or wheezing during or shortly after exercising?  | Yes | No        |
| 6. Have you ever had a heart murmur, racing heart or irregular heart beat?  | Yes | No        |
| 7. Have you ever been dizzy or passed out during exercise?*   | Yes | No        |
| 8. Has any family member ever had a heart attack or died suddenly before age 50?  | Yes | No        |
| 9. Do you have chest pain or tire more easily than others your age when exercising?   | Yes | No        |
| 10. Have you ever suffered heat related problems such as heat cramps, severe headache, dizziness or passing out?                      | Yes | No        |
| 11. Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint or persistent back/neck pain? | Yes | No        |
| 12. Have you ever had a concussion or been knocked unconscious?   | Yes | No        |
| 13. Have you ever had a seizure?  | Yes | No        |
| 14. Have you ever had burning pain, numbness or tingling in your arms or legs associated with any athletic or physical activity?      | Yes | No        |
| 15. Is there any other medical or family history which might be important?  | Yes | No        |
| 16. Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason?     | Yes | No        |
| 17. Have you ever required taping, padding or bracing before events or practice?  | Yes | No        |
| 18. Do you have damage or absence of one of any paired organs (i.e., kidney, testicle, eye, etc.)?                                    | Yes | No        |
| 19. Do you have any skin problems (rash, itching)?  | Yes | No        |
| 20. In the last year, how much weight have you gained or lost? _____  |     |           |
| 21. What is the date of your last tetanus booster? _____  |     |           |
| 22. What is the date of your last MMR? _____  |     |           |
| 23. Do you or any members of your family have a history of sickle cell trait?   | Yes | No        |
|   |     | Uncertain |

### For Females Only:

- |  |     |    |
|--|-----|----|
| 24. What is the date of your last menstrual period? _____                              |     |    |
| 25. In the last year have you gone for three months or more without a menstrual cycle? | Yes | No |

### Physical

height \_\_\_\_\_ blood pressure \_\_\_\_\_ \*>140/85? \_\_\_\_\_  
 weight \_\_\_\_\_ pulse \_\_\_\_\_  
 vision R corrected \_\_\_\_\_ uncorrected \_\_\_\_\_  
 L corrected \_\_\_\_\_ uncorrected \_\_\_\_\_  
 glasses \_\_\_\_\_ contact lenses R \_\_\_\_\_ L \_\_\_\_\_ both \_\_\_\_\_  
 general observations: \_\_\_\_\_  
 Tanner maturity staging: \_\_\_\_\_  
 HEENT: \_\_\_\_\_  
 Neck: ROM \_\_\_\_\_ palpation \_\_\_\_\_ tenderness \_\_\_\_\_  
 Chest: auscultation \_\_\_\_\_  
 wheezing? \_\_\_\_\_ Rales? \_\_\_\_\_  
 CV: heart murmur \_\_\_\_\_  
 \* murmur increase with valsalva? \_\_\_\_\_  
 \* murmur grade III or IV? \_\_\_\_\_  
 \* murmur diastolic? \_\_\_\_\_

rhythm \_\_\_\_\_ click \_\_\_\_\_ rub \_\_\_\_\_  
 pulses: carotid \_\_\_\_\_ radial \_\_\_\_\_ pedal (DP \_\_\_\_\_ PT \_\_\_\_\_)  
 edema? \_\_\_\_\_ cyanosis? \_\_\_\_\_

Abdomen \_\_\_\_\_  
 \* enlarged liver? \_\_\_\_\_ \* enlarged spleen? \_\_\_\_\_  
 hernia? \_\_\_\_\_ scars? \_\_\_\_\_  
 GU: male \_\_\_\_\_ testicles R \_\_\_\_\_ L \_\_\_\_\_  
 female \_\_\_\_\_  
 inguinal hernia? \_\_\_\_\_  
 Skin: gen. \_\_\_\_\_  
 rashes \_\_\_\_\_ impetigo \_\_\_\_\_ herpes s. \_\_\_\_\_  
 \*\*MS shoulder \_\_\_\_\_  
 elbow \_\_\_\_\_  
 wrist/hand \_\_\_\_\_  
 back \_\_\_\_\_  
 hip \_\_\_\_\_  
 knee \_\_\_\_\_  
 ankle \_\_\_\_\_  
 feet \_\_\_\_\_  
 other \_\_\_\_\_

identified problems: 1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_

recommendations coach/athletic trainer: \_\_\_\_\_  
 \_\_\_\_\_

\* Marfan? >2 (tall \_\_\_\_\_ striae \_\_\_\_\_ hyperextensibility \_\_\_\_\_)  
 upper to lower body ratio <0.9 \_\_\_\_\_ lens dislocation \_\_\_\_\_

\* requires additional evaluation

\*\* detailed exam if history of injury or problem

### The above named individual has been cleared for participation in the following sports:

- |       |  |
|-------|--|
| _____ | Contact collision (football, soccer, wrestling, etc.)      |
| _____ | Limited contact impact (baseball, basketball, volleyball)  |
| _____ | Noncontact strenuous (track, field, running, tennis, etc.) |
| _____ | Noncontact moderately strenuous (badminton, table tennis)  |
| _____ | Noncontact nonstrenuous (golf, archery, riflery)           |

### Additional evaluation suggested:

- |       |   |
|-------|---|
| _____ | none  |
| _____ | coach/athletic trainer notification and clearance |
| _____ | physician   |
|       | family physician _____                            |
|       | sports physician _____                            |
|       | orthopedic surgeon _____                          |
|       | other _____                                       |

Provider's/Physician's signature \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

(Physician's name [printed] must also appear if examination is given by an Advanced Nurse Practitioner or a Certified Physician's Assistant in written collaborative practice with a physician)

(continued on reverse side)

**Student Agreement Regarding Conditions for Participation:**

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understand the eligibility standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the citizenship standards set by the school or if I am ejected from an interscholastic contest because of an unsportsmanlike act, it could result in me not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate which requires me to list all previous injuries or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent Permission and Authorization for Treatment and Release of Medical Information:**

We hereby give our consent for the above student to represent his/her school in interscholastic athletics. We also give our consent for him/her to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it be enroute to or from another school or during practice or an interscholastic contest, and we hereby agree to hold the school district of which this school is a part, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with participation by my child/ward in any activities related to the interscholastic program of his/her school.

If we cannot be reached and in the event of an emergency, we also give our consent for the school to obtain through a physician or hospital of its choice, such medical care as is reasonably necessary for the welfare of the student, if he/she is injured in the course of school athletic activities. We authorize the release of necessary medical information to the physician, athletic trainer, and/or school personnel related to such treatment/care. We understand that the school may not provide transportation to all events, and **permit / do not permit** (CIRCLE ONE) my child to drive his/her vehicle in such a case.

We further state that we have completed that part of this certificate which requires us to list all previous injuries or additional conditions that are known to us which may affect this athlete's performance or treatment and we certify that it is correct and complete.

We confirm that this application for the above student to represent his/her school in interscholastic athletics is made with the understanding that we have studied and understand the eligibility standards that our son/daughter must meet to represent his/her school and that he/she has not violated any of them. We also understand that if our son/daughter does not meet the citizenship standards set by the school or if he/she is ejected from an interscholastic contest because of an unsportsmanlike act, it could result in him/her not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

The MSHSAA By-Laws provide that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic health/accident insurance coverage, which includes athletics. Our son/daughter is covered by basic health/accident insurance for the current school

year with \_\_\_\_\_  
(Name of Insurance Company)

\_\_\_\_\_  
(Policy Number) Date \_\_\_\_\_

Parents or Guardian's signature \_\_\_\_\_  
(All parents or guardians must sign)

\_\_\_\_\_ Date \_\_\_\_\_



*To be completed by athlete or parent:*

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City/State Zip Phone: (\_\_\_\_\_) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Family Physician: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Family Dentist: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Hospital Preference: \_\_\_\_\_