Dominion Academy Athletic Department

Pre-Participation Physical Evaluation – History Form

STUDENT INFORMATION: *(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)*

Student's Name | Date of Birth | Age | ❑ Male ❑ Female (Sex) | Grade (2017/2018)

Address | City | Zip Code

❑ Varsity Soccer ❑ Junior High Basketball ❑ Varsity Basketball ❑ Cheerleading ❑ Intramural Soccer
❑ Summer Soccer Program ❑ Summer Basketball Program

Sports Interested in Playing

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional, including energy drinks and protein supplements) that you are currently taking

_____

_____

Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergy below
❑ Medicines ❑ Pollens ❑ Food ❑ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats during exercise?		
8. Has a doctor ever told you that you have a heart problem? If so, check all that apply: ❑ High Blood Pressure ❑ Heart Murmur ❑ Heart Infection ❑ High Cholesterol ❑ Kawasaki Disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more shirt of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or SIDS)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arryhthmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or cathecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone on your family had unexplained fainting, unexplained seizures or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or game?		
18. Have you ever had any broke or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have had an x-ray for neck instability or atlantoaxial instability? (Down Syndrome or dwarfism)		

BONE AND JOINT QUESTIONS – CONTINUED	Yes	No
22. Do you regularly use a brace, orthotics or other assistive device?		
23. Do you have a bone, muscle or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**Yes**	**No**
26. Do you cough, wheeze, have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medications?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the past month?		
32. Do you have any rashes, pressure sores or other skin problems?		
33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches or memory problems?		
36. Do you have a history of seizure disorder or epilepsy?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had an eye injury?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to gain or lose weight? Has anyone recommended you do?		
49. Are you on a special diet or do you avoid certain types of food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Answer**	
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the past 12 months?		

Explain "Yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student | **Signature of Parent** | **Date**

DOMINION ACADEMY OF DAYTON

Dominion Academy Athletic Department
Pre-Participation Physical Evaluation

The Athlete With Special Needs – Supplemental History Form

STUDENT INFORMATION: *(Note: Please complete this form **ONLY** if your student has special needs or a disability.)*

❑ Male ❑ Female

Student's Name | Date of Birth | Age | Sex | Grade (2017/2018)

❑ Varsity Soccer ❑ Junior High Basketball ❑ Varsity Basketball ❑ Cheerleading ❑ Intramural Soccer
❑ Summer Soccer Program ❑ Summer Basketball Program

Sports Interested in Playing

Explain "Yes" answers below. Circle questions you don't know the answers to.

1.	Type of disability		
2.	Date of disability		
3.	Classification (if available)		
4.	Cause of disability		
GENERAL QUESTIONS		**Yes**	**No**
5.	Do you regularly use a brace, assistive device or prosthetic?		
6.	Do you use a special brace or assistive device for sports?		
7.	Do you have any rashes, pressure sores or any other skin problems?		
8.	Do you have a hearing loss? Do you use a hearing aid?		
9.	Do you have a visual impairment?		
10.	Do you have any special devices for bowel or bladder function?		
11.	Do you have burning or discomfort when urinating?		
12.	Have you had autonomic dysreflexia?		
13.	Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?		
14.	Do you have muscle spasticity?		
15.	Do you have frequent seizures that cannot be controlled by medication?		
HAVE YOU HAD ANY OF THE FOLLOWING		**Yes**	**No**
16.	Atlantoaxial instability		
17.	X-ray evaluation for atlantoaxial instability		
18.	Dislocated joints (more than one)		
19.	Easy bleeding		
20.	Enlarged spleen		
21.	Hepatitis		
22.	Osteopenia or osteoporosis		
23.	Difficulty controlling bowel		
24.	Difficulty controlling bladder		
25.	Numbness or tingling in arms or hands		
26.	Numbness or tingling in legs or feet		
27.	Weakness in arms or hands		
28.	Weakness in legs or feet		
29.	Recent change in coordination		
30.	Recent change in ability to walk		
31.	Spina bifida		
32.	Latex allergy		

Explain "Yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student | **Signature of Parent** | **Date**

Dominion Academy Athletic Department

Pre-Participation Physical Evaluation – Physician Form

STUDENT INFORMATION: *(Note: This form is to be filled out by the medical examiner.)*

Student's Name	Date of Birth	Age	❑ Male ❑ Female	Date of Physical Examination

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seatbelt, use a helmet or use condoms?
   - Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

PHYSICAL EXAMINATION

Height Weight ❑ Male ❑ Female

BP / (/) Pulse Vision R 20/ L 20/ Corrected ❑ Y ❑ N

MEDICAL	Normal	Abnormal Findings	MUSCULOSKELETAL	Normal	Abnormal Findings
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Neck		
Eyes/Ears/Nose/Throat: Pupils Equal Hearing			Back		
Lymph Nodes			Shoulder/Arm		
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)			Elbow/Forearm		
Pulses Simultaneous femoral and radial pulses			Wrist/Hand/Fingers		
Lungs			Hip/Thigh		
Abdomen			Knee		
Genitourinary (males only)			Leg/Ankle		
Skin HSV, lesions suggestive of MRSA, tinea corporis			Foot/Toes		
Neurologic			Functional Duck Walk, Single Leg Hop		

- Consider ECG, echocardiogram or referral to cardiology for abnormal cardiac history or exam
- Consider GU exam if in private setting. Having third party present is recommended.
- Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

CLEARANCE FORM

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

❑ Not Cleared

❑ Pending further evaluation ❑ For any sports ❑ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type)	Phone Number	Date of Exam

Address

Signature of physician or medical examiner **MD, DO, D.C., P.A., or A.N.P.**