



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

Male  Female

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade (2019/2020) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Varsity Soccer     Junior High Volleyball     High School Volleyball     Junior High Basketball     High School Basketball  
 Cheerleading     Summer Soccer     Summer Volleyball     Summer Basketball     Summer Cheer Camp

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	BONE AND JOINT QUESTIONS – CONTINUED	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			22. Do you regularly use a brace, orthotics or other assistive device?		
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____			23. Do you have a bone, muscle or joint injury that bothers you?		
3. Have you ever spent the night in the hospital?			24. Do any of your joints become painful, swollen, feel warm or look red?		
4. Have you ever had surgery?			25. Do you have any history of juvenile arthritis or connective tissue disease?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	<b>Yes</b>	<b>No</b>	<b>MEDICAL QUESTIONS</b>	<b>Yes</b>	<b>No</b>
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			26. Do you cough, wheeze, have difficulty breathing during or after exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			27. Have you ever used an inhaler or taken asthma medications?		
7. Does your heart ever race or skip beats during exercise?			28. Is there anyone in your family who has asthma?		
8. Has a doctor ever told you that you have a heart problem? If so, check all that apply: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease Other: _____			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			31. Have you had infectious mononucleosis (mono) within the past month?		
11. Have you ever had an unexplained seizure?			32. Do you have any rashes, pressure sores or other skin problems?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>Yes</b>	<b>No</b>	34. Have you ever had a head injury or concussion?		
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)?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches or memory problems?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?			36. Do you have a history of seizure disorder or epilepsy?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			37. Do you have headaches with exercise?		
16. Has anyone on your family had unexplained fainting, unexplained seizures or near drowning?			38. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
<b>BONE AND JOINT QUESTIONS</b>	<b>Yes</b>	<b>No</b>	39. Have you ever been unable to move your arms or legs after being hit or falling?		
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or game?			40. Have you ever become ill while exercising in the heat?		
18. Have you ever had any broke or fractured bones or dislocated joints?			41. Do you get frequent muscle cramps when exercising?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?			42. Do you or someone in your family have sickle cell trait or disease?		
20. Have you ever had a stress fracture?			43. Have you had any problems with your eyes or vision?		
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)			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?		
			<b>FEMALES ONLY</b>	<b>Answer</b>	
			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?		
			<b>Explain "Yes" answers here</b>		
			_____		
			_____		

**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 \_\_\_\_\_



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.)

Student's Name, Date of Birth, Age, Sex, Grade (2019/2020), Varsity Soccer, Junior High Volleyball, High School Volleyball, Junior High Basketball, High School Basketball, Cheerleading, Summer Soccer, Summer Volleyball, Summer Basketball, Summer Cheer Camp, Sports Interested in Playing

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

Table with 3 columns: Question, Yes, No. Contains 32 numbered questions about disabilities and medical history.

Explain "Yes" answers here

Blank lines for explaining 'Yes' answers to the questions above.

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


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

Student's Name	Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> 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		<input type="checkbox"/> Male <input type="checkbox"/> Female		
BP	/	( / )	Pulse	Vision R 20/	L 20/
					Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	Normal	Abnormal Findings	MUSCULOSKELETAL		
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			Normal	Abnormal Findings	
Eyes/Ears/Nose/Throat: Pupils Equal Hearing				Neck	
Lymph Nodes				Back	
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI)				Shoulder/Arm	
Pulses Simultaneous femoral and radial pulses				Elbow/Forearm	
Lungs				Wrist/Hand/Fingers	
Abdomen				Hip/Thigh	
Genitourinary (males only)				Knee	
Skin HSV, lesions suggestive of MRSA, tinea corporis				Leg/Ankle	
Neurologic				Foot/Toes	
				Functional Duck Walk, Single Leg Hop	

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

**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	<b>MD, DO, D.C., P.A., or A.N.P.</b>
--	--------------------------------------