

HIGH SCHOOL ATHLETIC PARTICIPATION SCREENING FORM

Name: _____ Grade: _____ M/F
 (PRINT LEGIBLY) Last First Middle or Nickname (In Fall) Circle
 Birthdate: _____ ID#: _____ Sport: _____ Fall _____ Winter _____ Spring

HEALTH HISTORY TO BE COMPLETED BY PARENT OR GUARDIAN

- Has your child: ↓ If you answer "YES" to any questions, please explain below ↓
1. Had a medical illness or injury that has disqualified him/her from athletic participation? YES NO
 2. Ever been hospitalized or undergone any surgical operations(s)? YES NO
 3. Had an ongoing chronic or serious illness (such as diabetes, kidney problems, seizures or asthma)? YES NO
 4. Ever taken any supplements or vitamins to help gain/lose weight or improve athletic performance? YES NO
 5. Ever passed out during/after exercise or become ill from exercising? YES NO
 6. Ever tired earlier than expected during exercise or complained of extreme fatigue? YES NO
 7. Ever had chest pain or unusual/irregular heartbeats during or after exercise? YES NO
 8. Had any history of heart problems, heart murmur, high blood pressure or high cholesterol? YES NO
 9. Had any family member or relative die before the age of 50 or die of heart-related problems? YES NO
 10. Had any family history of specific heart issues? If "YES," check all that apply: YES NO
 Hypertrophic Cardiomyopathy Arrhythmia Marfan's Syndrome Long QT Syndrome
 11. Had any history of concussion, head injury, loss of memory or being unconscious? YES NO
 12. Had any history of seizures, convulsions or fainting episodes? YES NO
 13. Had frequent or severe headaches? YES NO
 14. Ever had a "stinger," "burner," or pinched nerve (numbness or tingling down an extremity)? YES NO
 15. Had any problems with vision that require glasses, contacts, or protective eyewear? YES NO
 16. Born without or missing a kidney, eye, testicle, or any other organ? YES NO
 17. Had special protective or corrective equipment/devices that are not usually used for sports? YES NO
 Examples: knee brace, neck roll, foot orthotics, retainer for teeth, hearing aids?
 18. Been diagnosed with a contagious skin condition within the past month? YES NO
 19. Ever broken/fractured any bones or dislocated any joints? YES NO
 20. Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints? YES NO
 21. Currently under the care of a physician for any medical, orthopedic or emotional concerns? YES NO
 22. Had any history of asthma, allergies to foods, medicines, or stinging insects? YES NO
 If "YES," what medications are used? Is Epi-Pen needed? _____
 23. Require any special health procedure(s) during the regular school day or during athletics? YES NO
 24. **Females Only:** Have you had a menstrual period? Y__/N__; Age at first menstrual period:____; # of periods in last year:____
 25. Currently taking any prescription or "over-the-counter" medications or using an inhaler or Epi-Pen? YES NO
 If "YES," list all medications:
 Medication: _____ Dose: _____ Frequency: _____
 Medication: _____ Dose: _____ Frequency: _____
 Medication: _____ Dose: _____ Frequency: _____

↓ If you have answered "YES" to any of the above questions, please explain below ↓

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct and I give my permission for a physical exam to be completed.

Date: _____ Signature of Parent/Guardian: _____
 Signature of Student: _____

PHYSICAL SCREENING TO BE COMPLETED BY HEALTHCARE PROVIDER THIS IS NOT A COMPLETE PHYSICAL EXAMINATION

	Normal	Normal
General:		Musculoskeletal:
Appearance		Neck and shoulders
Eyes, ears, nose, throat		Spine
Cardiovascular		Arms/hands
Pulses		Hips/thighs
Chest and lungs		Knees
Abdomen		Ankles/feet
Skin		
Genitourinary (if indicated):		

Visual acuity (Distance): Right: / Left: /
<input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected
Height: _____
Weight: _____
Blood pressure: _____
Pulse: _____
DATE OF EXAM: _____

Recommendation: Full activity-No restrictions Activity with restrictions No contact sports No participation Other

Comments: _____

Examining Healthcare Provider: _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Healthcare Provider Office Stamp