ATHLETIC PRE-PARTICIPATION FORMS

Part A – Health History and List of Medications

STUDENT HEALTH HISTORY FORM

Name: _____ **Date of Birth:** _____

Age: _____ (x/x/xxxx) **Sex:** ☐ Male ☐ Female **Grade:** ____ **School:** _____

Sport(s): _____

Home Address: _____ **Cell/Home Phone #:** _____ (xxx-xxx-xxxx)

Personal Physician: _____ **Phone #:** _____ (xxx-xxx-xxxx)

In case of an emergency contact: N a m e :

_____ **Relationship:** _____ **Phone #:** _____ (xxx-xxx-xxxx) **w** _____ (xxx-xxx-xxxx)

HEALTH QUESTIONS

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition like diabetes or asthma? If yes, what _____	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Has a doctor ever told you that you have: (check all that apply) ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (ex. EKG, Echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have your ever had an injury (sprain, muscle, ligament tear, tendinitis) that caused you to miss a practice or game? If yes, where? _____	☐	☐
18. Have you had any broken or fractured bones, or dislocated joints? If yes, where? _____	☐	☐
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, where? _____	☐	☐
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had herpes skin infection?	☐	☐
31. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
32. Have you ever had a seizure?	☐	☐
33. Have you been hit in the head and been confused or lost your memory?	☐	☐
34. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	☐	☐
35. Do you have headaches with exercise?	☐	☐
36. Have you ever had a head injury or concussion?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control who eats?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period? _____		
49. How many periods have you had in the last year? ____		

List all medications (if any) currently taking: _____

If you answered yes to any of the questions above, please explain: _____

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

_____ Athlete's Signature

_____ Parent Signature

_____ Date

FULL STRIDE TRACK CLUB

ATHLETIC PRE-PARTICIPATION FORMS

Part B – Physician's Clearance to Participation

PHYSICAL EXAMINATION FORM

Student Name: _____ **Date of Birth:** _____ x/x/xxxx

Height: _____ **Weight:** _____ **% Body Fat (optional):** _____ **Pulse:** _____ **BP:** ___ / ___ (___ / ___ , ___ / ___)

Vision: R 20/_____ L 20/_____ **Corrected:** Yes **Pupils:** Equal_____ Unequal_____

Follow-Up Questions on More Sensitive Issues:

	Yes	No
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of our usual activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	☐	☐
5. During the past 30 days, did you use chewing tobacco, snuff or dip?	☐	☐
6. During the past 30 days, have you had at least 1 drink of alcohol?	☐	☐
7. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/Healthy Youth/yrba/index.htm) on guns, seat belts, unprotected sex, domestic violence, drugs, etc.	☐	☐

Notes: _____

	Normal	Abnormal Findings	Initials
Medical			
Appearance	☐		
Eyes/ears/nose/throat	☐		
Hearing	☐		
Lymph nodes	☐		
Heart	☐		
Murmurs	☐		
Pulses	☐		
Lungs	☐		
Abdomen	☐		
Hernia	☐		
Skin	☐		
Musculoskeletal			
Neck	☐		
Back	☐		
Shoulders/arms	☐		
Elbows/forearms	☐		
Wrists/hands/fingers	☐		
Hips/thighs	☐		
Knees	☐		
Legs/ankles	☐		
Feet/toes	☐		

To be completed by Physician only:

I hereby certify _____ (Student's Name) **was examined by me on** _____ (Date) **and is physically fit to participate in sports.**

Name of Physician (print or type): _____

Address (street, city, zip): _____

_____ **License #** _____

Physician's Signature ☐ **M.D.** ☐ **D.O.** ☐ **D.C.**