HIGH SCHOOL ATHLETIC PRE-PARTICIPATION EXAM FORM   Circle One: IHS NHS UHS WHS PHS

Name: ____ Grade: __________ M/F
(PRINT LEGIBLY) Last First Middle or Nickname (In Fall) Circle

Birthdate: ________________ Student ID #: ________________ SPORT: ________Fall ________Winter ________Spring

Section A: REQUIRED 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.	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?		
17.	Been diagnosed with a contagious skin condition within the past month?	YES	NO
18.	Ever broken/fractured any bones or dislocated any joints?	YES	NO
19.	Had any recurring problems with pain or swelling in back, muscles, tendons, bones or joints?	YES	NO
20.	Is your child currently under the care of a physician for any medical, orthopedic or emotional concerns?	YES	NO
21.	Had any history of asthma, allergies to foods, medicines, or stinging insects?	YES	NO
	If "YES," what medications are used? Is Epi-Pen needed?		
22.	Does your child require any special health procedure(s) during the regular school day or during athletics?	YES	NO
23.	Is your child 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:

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

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

Parent/Guardian Signature: ____ **Date:** ______________

Section B: PHYSICAL EXAM REQUIRED FOR ALL ATHLETES: To be completed by HEALTHCARE PROVIDER

	Normal		Normal
General:		Chest/Lungs	
Eyes, ears, nose, throat		Neck	
Cardiovascular		Abdomen	
Femoral pulses		Skin	

Visual acuity (Distance): Right: /	Left: /
☐Corrected ☐Uncorrected	
Height:	Blood pressure:
Weight:	Pulse:

Musculoskeletal:	Normal		Normal		Normal
Neck/Shoulder		Hips/Thighs		Arms/Hands	
Spine		Knees		Ankles/Feet	

COMMENTS:

Recommendation: ☐Full activity-No restrictions ☐Activity with restrictions **(explain below)** ☐No contact sports ☐No participation ☐Other

Please explain restrictions: ____

Examining Medical Practitioner (please print): ____
MD/DO/NP/PA ONLY

Signature: ____

DATE OF EXAM:________________ ***Phone:*** ______________________

Healthcare Provider Office Stamp:

Required