Annapolis Christian Academy
3875 S. Staples, Corpus Christi, TX 78411
361-991-6004

PRE-PARTICIPATION HISTORY & PHYSICAL EXAM

Name:_____ Sex: M ___ F___ Age:____ DOB _____
Grade:_____ School:_____
Sport(s)**Please list All**_____
Address:_____
Phone: _____ Personal Physician:_____ None ____

*Emergency Contact :*Name:_____ Relationship:_____ Phone#(s):
_____

Attention parent or guardian and athlete: answers to the following questions are very important!!!
Please take the time, read through the questions, and answer to the best of your knowledge.

General Medical History: YES NO

1. Do you have asthma?..... Y__ N__
2. Do you have diabetes? ..... Y__ N__
3. Do you have high blood pressure? ..... Y__ N__
4. Do you have seizures? .....Y__ N__
5. Do you have sickle cell trait? .....Y__ N__
6. Do you have any other major medical problem? .....Y__ N__
7. Have you ever been hospitalized or had surgery? .....Y__ N_
8. Do you cough, wheeze or have trouble breathing with exercise? ..... Y__ N__
9. Do you use an inhaler? ..... Y__ N__
10. Do you have a single organ (testicle or kidney)?..... Y__ N__
11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? ..... Y__ N__
12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or improve performance? Y__ N__
13. Do you have any allergies (seasonal, insects, food, or medicines)? ..... Y__ N__
14. Have you ever had a rash or hives develop during or after exercise? ..... Y__ N__
15. Do you have any skin problems other than acne?..... Y__ N__
16. Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung," or a concussion?..... Y__ N__
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? ..... Y__ N__
18. Have you ever had a stinger, burner, or pinched nerve
19. Have you ever become ill from exercising in the heat? ..... Y__ N__
20. Have you had mononucleosis or any significant illness in the last 60 days?..... Y__ N__
21. Do you have trouble with your eyes/vision/ wear glasses? Y__ N__
22. Do you have trouble with your hearing/wear hearing aid(s)? Y__N_
23. Do you want to weigh more or less than you do now? .....Y__N__
24. Do you lose weight regularly to meet weight requirements for your sport or other reason? ..... Y__ N__
25. Do you feel stressed out, tired, or depressed? ..... Y__ N__
26. Are there any other issues you would like to discuss with the doctor?..... Y__ N__
27. Are your immunizations up to date? …… Y__ N__

FEMALES ONLY

27. Are your periods regular (every month)? ..... Y__ N__
28. Are your periods heavy?.....

Explain "YES" answers here *(use back/page 2 if needed)*:

_____
_____
_____

_____
_____

Cardiac History: YES NO

1. Have you ever passed out during or after exercise?..... Y__ N__
2. Have you ever been dizzy during or after exercise? ..... Y__ N__
3. Have you ever had chest pain or chest pressure during or after exercise? ..... Y__ N__
4. Do you tire easily or more quickly than your friends during exercise?..... Y__ N__
5. Have you ever had racing of your heart or skipped heartbeats?..... Y__ N__
6. Have you ever been told you had a heart murmur?..... Y__ N__
7. Have you ever been told you had an enlarged or weak heart? ..... Y__ N__
8. Has any member of your family:
-died of heart problems or sudden death before age 50?..... Y__ N__
-been told they had a serious heart problem before age 50?.....Y__ N__
been told they had Marfan's syndrome?..... Y__ N__
9. Has a physician ever denied or restricted your participation in sports? ..... Y__ N__

Explain "YES" answers here:

_____
_____
_____
_____

Orthopaedic History: YES NO

1. Have you ever broken or fractured any bones? ..... Y__ N__
2. Have you ever subluxed or dislocated any joint?..... Y__ N__
3. Have you had any other problems related to your:
-neck, spine, or back?..... Y__ N__
-shoulders?..... Y__ N__
-elbows? .....Y__N__
wrists, hands, or fingers?.....Y__ N__
-hips?.....Y__ N__
-knees?..... Y__ N__
-ankles, feet, or toes? ..... Y__ N__
-other?..... Y__ N__

Explain "YES" answers here *(put date of injury if known)*:_____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Vision: L20/ R20/ Both Corrected: Y N BMI_____
Height Weight Pulse B/P (R arm)

Medical Normal Abnormal Findings
Appearance/Emotional Affect
Head/Eyes/Ears/Nose/Throat
Lymph Nodes
Heart (squatting to standing and supine)
Pulses (include femoral)
Lungs
Abdomen
Genitalia (males only)
Skin

Musculoskeletal Normal Abnormal Findings
Neck
Back
Shoulder/Arm
Elbow/Forearm
Wrist/Hand
Hip/Thigh
Knee
Leg/Ankle
Foot

May Participate in all sports, *EXCEPT* those listed below:
_____
May Participate after completing evaluation/rehabilitation for: _____
_____
_____
May Not Participate – Reason: _____
_____
Recommendations: _____
_____
Signature of M.D. _____ **Date of Exam:** _____
Printed Name:_____ **Office Stamp**
Phone Number: _____
Extra Space for "YES" answers from the front: _____
_____
_____