

Annapolis Christian Academy
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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? Y ___ N ___

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: _____
