ATHLETIC PRE-PARTICIPATION HISTORY FORM

Student's Name____ Birthdate_____________ Male/Female Grade______

HEALTH HISTORY (The following questions should be completed by the student athlete with the assistance of a parent or guardian. Explain all "Yes" answers at the bottom of the page. A parent or guardian's signature in required.)

MEDICAL HISTORY OF ATHLETE	Yes	No	Don't Know	MEDICAL HISTORY OF ATHLETE	Yes	No	Don't Know
1. Has a doctor ever denied or restricted your participation in sports for any reason?				11. Have you ever had a head injury or concussion?			
2. Have you had a medical illness or injury since your last checkup or sports physical?				12. Do you have a history of seizures?			
3. Do you have any ongoing medical conditions (like diabetes, asthma or high blood pressure)?				13. Have you ever become ill from exercising in the heat?			
4. Are you currently taking any medications? If yes, list below				14. Have you ever had surgery?			
5. Do you have allergies to medicines, foods or bee stings?				15. Do you use a brace or protective device during sports activities?			
6. Has anyone in your family (mother, father, grandmother, grandfather, brother, sister) died suddenly before the age of 50?				16. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?			
7. Have you ever stopped exercising due to dizziness or passed out while exercising?				17. Have you had any problems with your eyes or vision?			
8. Have you ever been told that you have a heart murmur or heart problem?				18. Do you wear contacts or glasses?			
9. Do you have asthma (wheezing), hay fever, or coughing spells after exercise?				19. Do you have any concerns that you would like to discuss with a doctor?			
10. Have you ever experienced chest pain or your heart racing or skipping beats during exercise?				20. What is the date of your last Tetanus immunization? Date:_____________________			

Please explain all "Yes" answers here:

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Please list medications here:

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Parent or Guardian Signature

I have answered / reviewed the questions above and give permission for my child to participate in athletic activities.

______________________________________ / ______________________________

Signature of Parent or Guardian Date

PHYSICAL EXAMINATION RECORD

Student's Name:____

Height__________ Weight__________ Pulse__________ BP__________ Vision (R)_________ (L)_________

	Normal	Abnormal Findings
1. Appearance		
2. Eyes/Ears/Nose/Throat		
3. Mouth & Teeth		
4. Neck		
5. Lymph Nodes		
6. Heart		
7. Chest & Lungs		
8. Abdomen		
9. Genitalia		
10. Skin		
11. Musculoskeletal		
12. Neurological		

Other comments regarding abnormal findings or concerns:____

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ATHLETIC PARTICIPATION RECOMMENDATIONS

__________Full & Unlimited Participation

__________Limited Participation - May **NOT** participate in the following:_______________________________

__________Clearance Pending Documented Follow Up of_______________________________

__________NOT Cleared for Athletic Participation - List Reason_______________________________

Please Print / Stamp

Physician's Name____

Street Address____

City, State, Zip Code____

Telephone____

I certify that I have examined the above student and that I am a licensed medical physician, physician's assistant, or nurse practitioner.

____ _______________________

Physician's Signature Date