PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name:_____Sex _____ Age_____ Date of Birth _____

Address _____Phone _____

Personal Physician_____Phone _____

In case of emergency, contact:

Name _____Relationship _____ Phone (H) _____(W) _____

Circle Y for *yes* and N for *no*. Explain "Yes" answers below. Circle questions you don't know the answers to. *Any Yes answer to questions 1, 2, 5, 7, 11, or 17 requires further medical evaluation which may include a physical examination*. *See below**

1. Have you had a medical illness or injury since your last check up or sports physical?	**Y**	**N**
2. Have you been hospitalized overnight in the past year?	**Y**	**N**
3. Have you had surgery in the past year?	**Y**	**N**
4. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	**Y**	**N**
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	**Y**	**N**
6. Have you ever passed out during or after exercise?	**Y**	**N**
Have you ever been dizzy during or after exercise?	**Y**	**N**
Have you ever had chest pain during or after exercise?	**Y**	**N**
Do you get tired more quickly than your friends do during exercise?	**Y**	**N**
Have you ever had racing of your heart or skipped heartbeats?	**Y**	**N**
Have you had high blood pressure or high cholesterol?	**Y**	**N**
Have you ever been told you have a heart murmur?	**Y**	**N**
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	**Y**	**N**
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	**Y**	**N**
Have you had a severe viral infection (for example, Myocarditis or mononucleosis) within the last month?	**Y**	**N**
Has a physician ever denied or restricted your participation in sports for any heart problems?	**Y**	**N**
7. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	**Y**	**N**
8. Have you ever had a head injury or concussion?	**Y**	**N**
Have you ever been knocked out, become unconscious, or lost your memory?	**Y**	**N**
If yes, how many times? _____		
When was the last concussion? _____		
How severe was each one? (Explain below.)		
Have you ever had a seizure?	**Y**	**N**
Do you have frequent or severe headaches?	**Y**	**N**
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	**Y**	**N**
Have you ever had a stinger, burner, or pinched nerve?	**Y**	**N**
9. Have you ever become ill from exercising in the heat?	**Y**	**N**
10. Have you ever gotten unexpectedly short of breath with exercise?	**Y**	**N**
Do you cough, wheeze, or have trouble breathing during or after activity?	**Y**	**N**
Do you have asthma?	**Y**	**N**
Do you have seasonal allergies that require medical treatment?	**Y**	**N**
11. Have you had any problems with your eyes or vision?	**Y**	**N**
12. Are you missing any paired organs?	**Y**	**N**
13. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	**Y**	**N**
14. Have you ever had a sprain, strain, or swelling after injury?	**Y**	**N**
Have you broken or fractured any bones or dislocated any joints?	**Y**	**N**
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	**Y**	**N**

If yes, check appropriate line and explain below.

_____ Head	_____ Elbow	_____ Hip
_____ Neck	_____ Forearm	_____ Thigh
_____ Back	_____ Wrist	_____ Knee
_____ Chest	_____ Hand	_____ Shin/Calf
_____ Shoulder	_____ Finger	_____ Ankle
_____ Upper Arm	_____ Foot	

15. Record the dates of your most recent immunizations (shots) for:

Tetanus Measles _____

Hepatitis B Chickenpox _____

16. Are you under a doctor's care?	**Y**	**N**

***Explain "Yes" answers here:** (A "yes" on questions 1, 2, 5, 7, 11 or 17 requires a* further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in practices, games or matches. It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither Sweethaven Christian Academy nor the coaches assume any responsibility in case an accident occurs. If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student. If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

To the Parent:

Check any activity in which this student is allowed to participate.

_____ **Volleyball** _____ **Soccer** _____ **Basketball** _____ **Cheerleading**

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

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name_____Sex _____ Age _____ Date of Birth _____
Height_____ Weight _____ % Body fat (optional) _____ Pulse _____ BP____/____
Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

As a minimum requirement, this **Physical Examination Form** must be completed prior to athletic participation every school year. It ***must*** be completed if there are "yes" answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side.

	NORMAL	ABNORMAL	FINDINGS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

o Cleared

o Cleared after completing evaluation/rehabilitation for:

_____
_____
_____

o Not cleared for: _____Reason: _____
Recommendations:_____
_____
_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type)_____ Date of Examination:_____

Address: _____

PhoneNumber:_____

Signature: _____

Must be completed before a student participates in any practice, before, during, or after school, (both in-season and out-of-season) or games/matches.