

St. Clair County Medical Society Pre-Participation Athletic Screening Physical

Name: _____ Sex: Male Female Age: _____ Date of Birth: _____
 Address: _____ Phone Number: (____) _____ - _____
 School: _____ Grade: _____ Sport(s): _____
 Personal Physician: _____

In Case of Emergency, Contact: Name: _____
 Relationship: _____ Phone(H): (____) _____ - _____ (W) (____) _____

History to be completed by parent or guardian. If you answer yes to any of the questions below, please explain.

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical illness or injury since your last checkup or sports physical? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an ongoing or chronic illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any prescription or non-prescription (over the counter) medications, pills or inhalers? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies (examples: pollen, medicine, food or stinging insects)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a rash or hives develop during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever passed out during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been dizzy during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get tired more quickly than your friends do during exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had racing of your heart or skipped heartbeats? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had high blood pressure or high cholesterol? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have a heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has any family member or relative died of heart problems or sudden death before the age of 50? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a severe viral infection (example: myocarditis or mononucleosis) within the last month? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has a physician ever denied or restricted your participation in sports for any heart problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any current skin problems? (examples: itching, rashes, acne, warts, fungus or blisters)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a head injury or concussion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been knocked out, become unconscious, or lost your memory? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a seizure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent or severe headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had numbness or tingling in your arms, hands, legs or feet? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever become ill from exercising in the heat? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you cough, wheeze or have trouble breathing during or after activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problems with your eyes or vision? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a sprain, strain or swelling after injury? |

	Mo/Day/Yr of Dose	Health Provider	Date of Next Dose Due
Diphtheria-Tetanus-Pertussis DTaP/DTP/DT/Td (specify Type)	1.		
	2.		
	3.		
	4.		
	5.		
Haemophilus Influenzae Type b (Hib)	1.		
	2.		
	3.		
	4.		
Polio IPV/OPV (specify type)	1.		
	2.		
	3.		
	4.		
MMR	1.		
	2.		
Varicella	1.		
	2.		
Hepatitis B HBV	1.		
	2.		
	3.		
Pneumococcal Conjugate	1.		
	2.		
	3.		
	4.		
Other Vaccines			
Notes			

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a stinger, burner or pinched nerve? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contacts or protective eyewear? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you broken or fractured any bones or dislocated any joints? |

Explain "yes" answers here: _____

I give my permission that the child/student named above may participate in interscholastic athletics knowing the injuries that might occur and I consent to first aid care rendered should it be needed. I understand that the physician will not be performing a complete physical examination, and will not be liable for civil damages as a result of acts or omissions in performing the examination except for gross negligence, willful and wanton misconduct, or actions outside the scope of the physician's license. I, the parent or guardian, understand that not all life-threatening medical conditions can be detected on these pre-participation screening examinations.

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

Signature of Parent/Guardian: _____ Date: _____

Pre-Participation Physical Evaluation Screening

To be completed by medical personnel

Name: _____

Birth Date: / /

Pulse: _____

BP / / /

Medical	Normal	Abnormal Findings	Initials
Eyes/Ears/Nose/Throat			
Heart			
Lungs			
Genitalia (males only)			
MUSCULOSKELETAL			
Neck/Back			
Shoulder/Elbow			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below.

Baseball ▪ Basketball ▪ Cheerleading ▪ Cross Country ▪ Football ▪ Golf ▪ Gymnastics ▪ Ice Hockey
Skiing ▪ Soccer ▪ Softball ▪ Swimming ▪ Tennis ▪ Track ▪ Volleyball ▪ Wrestling

Cleared _____ MD/DO _____
Physician Signature Date

Not Cleared For: _____

Recommendations: _____

_____ MD/DO _____
Physician Signature Date

Family Physician/
Cleared _____ MD/DO _____
Physician Signature Date