

PREPARTICIPATION HISTORY AND EXAMINATION

Parents: Please complete and sign the top half in advance. The purpose of this exam is to check for some detectable conditions which might affect a student's participation in sports. Students with health problems should have a regular appointment with their doctor.

Name: _____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____

I give permission for this exam, and I release Dayton Schools and the doctor from liability for conditions which can't be readily detected during a screening exam. The information is complete to the best of my knowledge.

Signature of Parent/Guardian _____ Date: _____

History

- | | | Yes | No | |
|-----|----|--------------------------|--------------------------|---|
| 1. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a recurrent illness? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an illness lasting more than a week? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| | f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any surgery other than a tonsillectomy? |
| | g. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| | h. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils? (appendix, eye, kidney, testicle, etc.)? |
| 2. | | <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking ANY medications (including birth control, pill, vitamin, aspirin, etc.)? |
| 3. | | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack, or sudden death before age 50? |
| 5. | | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any fainting, convulsions, seizures or severe dizziness? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or a "pinched nerve"? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury? |
| 7. | | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eye glasses, contact lenses or protective eye wear? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 10. | | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate or retainer? |
| 11. | a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| | b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| | c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| | d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| | e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint or had to use crutches? |
| | f. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than five years since your last booster shot? |
| 13. | | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. | | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you had any menstrual problems? |
| 15. | | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any medical concerns about participating in your sport? |

Athlete should not write below this line.

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number).

PHYSICAL EXAMINATION

Optional

Age: _____ Pulse: _____

Urinalysis: _____

Height: _____ BP: _____

Body Fat %: _____

Weight: _____ Visual Acuity: Left: _____
Right: _____

HCT: _____

EST VO2 max: _____

Audiometry: _____

Normal

Abnormal

- | | | |
|---|--------------------------|-------|
| <input type="checkbox"/> 1. Head | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 2. Eyes (pupils) ENT | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 3. Teeth | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 4. Chest | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 5. Lungs | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 6. Heart | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 7. Abdomen | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 8. Genitalia | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 9. Neurologic | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 10. Skin | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 11. Physical Maturity | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 12. Spine, back | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 13. Shoulders, Upper Extremities | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> 14. Lower Extremities | <input type="checkbox"/> | _____ |

- Assessment: Full participation
 Limited participation (describe limitations, restrictions):

- Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

DATE: _____

EXAMINER'S SIGNATURE: _____

EXAMINER'S PHONE: () _____

PRINT EXAMINER'S NAME: _____