

# PREPARTICIPATION EXAMINATION

**To be completed by athlete or parent:**

NAME: \_\_\_\_\_  
Last                      First                      Middle

SPORT: \_\_\_\_\_

School ID #: \_\_\_\_\_

YEAR: Fr. So. Jr. Sr. 5<sup>th</sup> \_\_\_\_\_

PHONE #: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

SCHOOL ADDRESS: \_\_\_\_\_  
Street                                      City                                      Zip

PARENTS NAME(S): \_\_\_\_\_  
Mother                                      Father

PARENTS ADDRESS: \_\_\_\_\_  
Street                                      City                                      Zip

PARENTS PHONE #: \_\_\_\_\_  
Home                                      Work                                      Cell

FAMILY DOCTOR: \_\_\_\_\_  
Name                                      Phone #

| <b>Past Medical History:</b>  | <b>YES</b>  | <b>NO</b> | <b>If yes, Please Explain.<br/>Dates if Possible.</b> |
|---|-------------|-----------|---|
| 1. Presently taking medications (including birth control)   | _____       | _____     | _____   |
| 2. Allergic to medications, bee stings, foods?  | _____       | _____     | _____   |
| 3. Wears any appliances – glasses, contact lenses?  | _____       | _____     | _____   |
| 4. History of braces, chipped teeth, bridges?   | _____       | _____     | _____   |
| 5. Has ongoing medical problem?   | _____       | _____     | _____   |
| 6. Had serious or significant illness in past?  | _____       | _____     | _____   |
| 7. Any past surgeries? (sports or non-sport related)  | _____       | _____     | _____   |
| 8. Any past injuries directly related to sports?  | _____       | _____     | _____   |
| 9. Any hospitalizations not explained above?  | _____       | _____     | _____   |
| 10. Any known deformities (such as curvatures of the spine, heart problems, one kidney, one eye, one testicle, etc.)? | _____       | _____     | _____   |
| 11. Any serious family illness (such as diabetes, bleeding disorders, heart attack before age 50, etc.)?              | _____       | _____     | _____   |
| 12. Any fainting or dizziness while exercising?   | _____       | _____     | _____   |
| 13. Any loss of consciousness, concussion, or head injury?  | _____       | _____     | _____   |
| 14.     A. Last Tetanus shot  | DATE: _____ |           |   |
| B. Last Dental examination  | DATE: _____ |           |   |
| C. Last Eye examination   | DATE: _____ |           |   |
| D. Last Menstrual period (if woman)   | DATE: _____ |           |   |

**Personal habits (please indicate use of any of the following):**

- |  |       |       |       |
|--|-------|-------|-------|
| 1. Tobacco products                              | _____ | _____ | _____ |
| 2. Alcohol                                       | _____ | _____ | _____ |
| 3. Steroids                                      | _____ | _____ | _____ |
| 4. Recreational drugs (marijuana, cocaine, etc.) | _____ | _____ | _____ |

**Review of systems (Please check if you have any problems with any of the following areas):**

|       |                |       |           |       |                    |
|-------|----------------|-------|-----------|-------|--------------------|
| _____ | Skin           | _____ | Lungs     | _____ | Shoulders, Arms    |
| _____ | Head           | _____ | Heart     | _____ | Hips, Legs, Feet   |
| _____ | Eyes           | _____ | Abdomen   | _____ | Muscles – Strength |
| _____ | Ears           | _____ | Back      | _____ | Mental, Emotional  |
| _____ | Nose           | _____ | Urination | _____ | Bowel control      |
| _____ | Hands          | _____ | Feeling   | _____ | Mouth/Throat       |
| _____ | Neck           | _____ | Fatigue   | _____ | Nutrition          |
| _____ | Weight Control | _____ | Genital   | _____ | Other? _____       |

I certify that the above information is correct to the best of my knowledge:

Student Signature: \_\_\_\_\_

Parent (if under 18): \_\_\_\_\_

• ***Physical Examination: (Completed by Physician)***

Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Respiratory \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Liver: \_\_\_\_\_ Spleen: \_\_\_\_\_ Hernia: \_\_\_\_\_

Significant Past Illness or Injury: \_\_\_\_\_

| ORTHOPEDIC ASSESSMENT                                  | <b>L</b>                 | (Please use space below for any special notes or tests) | <b>R</b>                 |
|--|--------------------------|---|--------------------------|
| Ankles<br>- Range Of Motion<br>- Anterior Drawer       | WNL<br>+ -               |   | WNL<br>+ -               |
| Knees<br>- ROM<br>- MCL/LCL<br>- ACL/PCL<br>- Meniscal | WNL<br>+ -<br>+ -<br>+ - |   | WNL<br>+ -<br>+ -<br>+ - |
| Hips<br>- ROM<br>- Other                               | WNL<br>+ -               |   | WNL<br>+ -               |
| Shoulders<br>- ROM<br>- Empty Can<br>- Other           | WNL<br>+ -<br>+ -        |   | WNL<br>+ -<br>+ -        |
| Elbows<br>- ROM<br>- OTHER                             | WNL<br>+ -               |   | WNL<br>+ -               |
| Wrist<br>- ROM<br>- Other                              | WNL<br>+ -               |   | WNL<br>+ -               |
| Spine<br>- Cervical<br>- Thoracic<br>- Lumbar          | WNL<br>WNL<br>WNL        |   | WNL<br>WNL<br>WNL        |

Athlete cleared without restrictions: **YES** **NO**

Athlete cleared with the following restrictions: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Athletic Trainer Signature: \_\_\_\_\_

Date: \_\_\_\_\_