Sports Pre-Participation History and Physical Examination

Patient Name: ______________________________ DOB: ____________________

History

Please review all questions with your parent or guardian and answer them to the best of your knowledge.

Yes	No	Don't Know	Questions
			1. Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother or sister) died suddenly before age 50?
			2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
			3. Has the athlete ever been told he/she has a heart murmur or heart problem?
			4. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
			5. Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint?
			6. Does the athlete have a history of concussion (getting knocked out)?
			7. Has the athlete ever suffered a heat-related illness (heat stroke or heat exhaustion)?
			8. Does the athlete have anything he/she wants to talk to the doctor about?
			9. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
			10. Does the athlete take any medicine?
			11. Is the athlete allergic to any medications or bee stings?
			12. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?
			13. Does the athlete wear contacts or eyeglasses?

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Sports Pre-Participation History and Physical Examination (continued)

To be completed by Physician:

BP:		Pulse:		Weight:		Height:		Vision - R:		Vision - L:	

Organ / System		Normal	Abnormal	Record laxity, weakness, instability, decreased ROM if abnormal
Cardiovascular				
Eyes / Pupils				
Neck				
Shoulders				
Knees				
Feet				
Scoliosis / Spine				
Other Orthopedic Problems				
ENT				
Lungs				
Abdomen				
Neurological				
Skin				
Genitalia				

Recommendations: ☐ Unlimited ☐ Deferred to personal physician

I certify that I have examined the above athlete and such examinations revealed no conditions which would prevent the athlete's participation in sports.

Physician Name: ______________________________

Physician Signature: ______________________________ Date: ______________

Address: ______________________________ Phone: (_____) __________-____________

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Consent For Treatment and Grant of In Loco Parentis Status

To be completed by Parent or Guardian:

Participant / Player Name: ____

Parent or Guardian Phone: (_________) ______________-_________________

Home Address: ____

City: ______________________________ State: ____________ Zip Code: ____________

Family Physician: ______________________________ Phone: (_____) __________-____________

Any medical condition an attending physician or EMT should know about in rendering First Aid or Emergency Treatment (list):

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

List of Allergies:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Required Medication(s): ______________________________ Blood Type: ____________________

Insurance Provider: ______________________________ Policy Number: ____________________

Parent or Guardian Name: ______________________________ Phone: (_____) __________-____________

Parent or Guardian Signature: ______________________________ Date: ____________________

NOTE: Parents will be notified in case of serious injury or illness as quickly as they can be reached, but this form will make immediate treatment possible.