**ORTING SCHOOL DISTRICT PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION**

**The following athlete is deemed “physically fit” to participate in Middle School AND High School Athletics. This physical is good for 24 months from the exam date.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Exam Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY**

 Yes No

1 a. [ ]  [ ]  Have you had any illness/injury recently, or do you have an illness/injury now?

 b. [ ]  [ ]  Have you had a medical problem, illness or injury since your last exam?

 c. [ ]  [ ]  Do you have any chronic or recurrent illness?

 d. [ ]  [ ]  Have you ever had any illness lasting more than a week?

 e. [ ]  [ ]  Have you ever been hospitalized overnight?

 f. [ ]  [ ]  Have you had any surgery other than tonsillectomy?

 g. [ ]  [ ]  Have you ever had any injuries requiring treatment by a physician?

 h. [ ]  [ ]  Do you have any organ missing other than tonsils ( appendix, eye, kidney, testicle, etc.)?

2. [ ]  [ ]  Are you presently taking ANY medications ( including birth control pill, vitamin, aspirin, etc.)?

3. [ ]  [ ]  Do you have ANY allergies (medicines, bees, foods, or other factors)?

4 a. [ ]  [ ]  Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?

 b. [ ]  [ ]  Do you tire more easily or quickly than your friends during exercise?

 c. [ ]  [ ]  Have you ever had any problem with your blood pressure or your heart?

 d. [ ]  [ ]  Have any close relatives had heart problems, heart attack or sudden death before they were age 50?

5. [ ]  [ ]  Do you have any skin problems (acne, itching, rashes, etc.)?

6 a. [ ]  [ ]  Have you ever had fainting, convulsions, seizures or severe dizziness?

 b. [ ]  [ ]  Do you have frequent severe headaches?

 c. [ ]  [ ]  Have you ever had a “stinger” or “burner” or “pinched nerve”?

 d. [ ]  [ ]  Have you ever been “knocked out” or “passed out”?

 e. [ ]  [ ]  Have you ever had a neck or head injury?

7. [ ]  [ ]  Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?

8. [ ]  [ ]  Have you had asthma, or trouble breathing, or cough during or after exercise?

9 a. [ ]  [ ]  Do you wear eyeglasses, contact lenses or protective eye wear?

 b. [ ]  [ ]  Have you had any problem with your eyes or vision?

10. [ ]  [ ]  Do you wear any dental appliance such as braces, bridge, plate, retainer?

11 a. [ ]  [ ]  Have you ever had a knee injury?

 b. [ ]  [ ]  Have you ever had an ankle injury?

 c. [ ]  [ ]  Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?

 d. [ ]  [ ]  Have you ever had a broken bone (fracture)?

 e. [ ]  [ ]  Have you ever had a cast, splint, or had to use crutches?

 f. [ ]  [ ]  Must you use special equipment for competition (pads, braces, neck roll, etc.)?

12. [ ]  [ ]  Has it been more than 5 years since your last tetanus booster shot?

13. [ ]  [ ]  Are you worried about your weight?

14. [ ]  [ ]  FEMALES: Have you any menstrual problems?

15. [ ]  [ ]  Have you 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:\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure:\_\_\_\_\_\_\_\_\_\_\_\_ | Body Fat % |
|  |  |
| Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Visual Acuity: Left 20/\_\_\_\_\_\_\_ | HCT: |
|  Right 20/ \_\_\_\_\_\_\_ |  |
|  | EST VO2 Max: |
|  |  |
|  | Audiometry: |
|  |  |

|  |  |
| --- | --- |
| Normal Abnormal |  |
| [ ]  1. Head [ ]  |  |
| [ ]  2. Eyes (pupils), ENT [ ]  |  |
| [ ]  3. Teeth [ ]  |  |
| [ ]  4. Chest [ ]  |  |
| [ ]  5. Lungs [ ]  |  |
| [ ]  6. Heart [ ]  |  |
| [ ]  7. Abdomen [ ]  |  |
| [ ]  8. Genitalia [ ]  |  |
| [ ]  9. Neurologic [ ]  |  |
| [ ]  10. Skin [ ]  |  |
| [ ]  11. Physical Maturity [ ]  |  |
| [ ]  12. Spine, Back [ ]  |  |
| [ ]  13. Shoulders, Upper extremities [ ]  |  |
| [ ]  14. Lower extremities [ ]  |  |

Assessment: [ ]  Full participation

 [ ]  Limited participation (describe limitations, restrictions):

 [ ]  Participation contraindicated (list reasons):

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

**EXAM DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXAMINER’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXAMINER’S PHONE: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRINT EXAMINER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**