**PARENTS' PERMISSION FOR SON OR DAUGHTER TO PARTICIPATE IN ATHLETICS**

TO: Principal or Superintendent:

As the parents or legal guardian of_____, I give my consent for his/her practice and play in the athletic events listed below and for the physical exam evaluation for that participation. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or emergency treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history on the preceding page is accurate to the best of my knowledge. I understand that the data acquired may be used for research purposes to improve athletic care.

**DATE**_____ **SIGNED**_____

(Father, mother, or Legal guardian)

## PREPARTICIPATION PHYSICAL EXAM

### VITAL SIGNS

HT WT (SKINFOLD mm) PULSES: WRIST R L

FEM

VISION R 20/ L 20/

(CORRECTED) DENTAL HEART RATE

R 20/ L 20/

BP

**CK NEG RECORD ABNORMALS** **CK NEG RECORD ABNORMALS**

### PHYSICAL

**DEFORMITY**

APPEARANCE

PUPILS

EENT

LUNG

HEART

ABDOMEN

GU

SKIN

LYMPH NODES

### MUSCLSKEL

**ROM INSTABIL**

C SPINE

T SPINE

LS SPINE

SHOULDER

ELBOW

WRIST

HAND

HIP

KNEE

ANKLE

FOOT

NOTES:

CLEARED (I)___ CROSS OUT SPORT NOT PERMITTED

FOOTBALL BASKETBALL BASEBALL SOFTBALL VOLLEYBALL WRESTLING FIELD HOCKEY

SOCCER CROSS COUNTRY TRACK TENNIS GOLF BOWLING CHEERLEADING SWIMMING

NEEDS FURTHER EVAL (II)____ EVALUATION BY_____

REHAB BY_____

SECONDARY CLEARANCE (I)_____MD or DO Date_____

NOT CLEARED(III)___ REASON:

COLLISION_____ CONTACT_____ NONCONTACT_____

STRENUOUS_____MODERATELY STRENUOUS_____NONSTRENUOUS_____

NAME OF PHYSICIAN OR FACILITY:

ADDRESS: PHONE:

SIGNATURE_____MD or DO Date_____

**HISTORY** PREPARTICIPATION PHYSICAL EVALUATION **DATE OF EXAM** _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____ Phone _____

Address _____

Personal Physician _____ IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____ Phone (H) _____ (W) _____

I II III A B C 1 2 3 a b c + - **Social Security #:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

PPE Inj Act FT PE

**FILL YES / NO BOXES** **Explain "Yes" answers below.**

| | | Yes | No |
|---|---|---|---|
| 1. | Have you had a medical illness or injury since your last check up or sports physical? | ❑ | ❑ |
| | Do you have an ongoing or chronic illness? | ❑ | ❑ |
| 2. | Have you ever been hospitalized overnight? | ❑ | ❑ |
| 3. | Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | ❑ | ❑ |
| | Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | ❑ | ❑ |
| 4. | Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ❑ | ❑ |
| | Have you ever had a rash or hives develop during or after exercise? | ❑ | ❑ |
| 5. | Have you ever passed out during or after exercise? | ❑ | ❑ |
| | Have you ever been dizzy during or after exercise? | ❑ | ❑ |
| | Have you ever had chest pain, chest discomfort, or unplained shortness of breath during or after exercise? | ❑ | ❑ |
| | Do you get tired more quickly than your friends do during exercise? | ❑ | ❑ |
| | Have you ever had racing of your heart or skipped heartbeats? | ❑ | ❑ |
| | Have you had high blood pressure or high cholesterol? | ❑ | ❑ |
| | Have you ever been told you have a heart murmur? | ❑ | ❑ |
| | Has any family member or relative died of heart problems or sudden death before age 50? | ❑ | ❑ |
| | Has any relative younger than 50 ever had disability from heart or cardiovascular disease ? | ❑ | ❑ |
| | Do you have, or do you know any family member or relative with ANY heart condition (Marfans, cardiomyopathy, or arrhythmia – irregular heartbeat) | ❑ | ❑ |
| | Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ❑ | ❑ |
| | Has a physician ever denied or restricted your participation in sports for any heart problems? | ❑ | ❑ |
| 6. | Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | ❑ | ❑ |
| 7. | Have you ever had a head injury or concussion? | ❑ | ❑ |
| | Have you ever been knocked out, become unconscious, or lost your memory? | ❑ | ❑ |
| | Have you ever had a seizure? | ❑ | ❑ |
| | Do you have frequent or severe headaches? | ❑ | ❑ |
| | Have you ever had numbness or tingling in your arms, hands, legs, or feet? | ❑ | ❑ |
| | Have you ever had a stinger, burner, or pinched nerve? | ❑ | ❑ |
| 8. | Have you ever become ill from exercising in the heat? | ❑ | ❑ |
| 9. | Do you cough, wheeze, or have trouble breathing during or after activity? | ❑ | ❑ |
| | Do you have asthma? | ❑ | ❑ |
| | Do you have seasonal allergies that require medical treatment? | ❑ | ❑ |

**Explain any "Yes" answers here:** _____

**Circle questions you don't know the answers to completely.**

| | | Yes | No |
|---|---|---|---|
| 10. | Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | ❑ | ❑ |
| 11. | Have you had any problems with your eyes or vision? | ❑ | ❑ |
| | Do you wear glasses, contacts, or protective eyeware? | ❑ | ❑ |
| 12. | Have you ever had a sprain, strain, or swelling after injury? | ❑ | ❑ |
| | Have you broken or fractured any bones or dislocated any joints? | ❑ | ❑ |
| | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | ❑ | ❑ |

| ANSWER BELOW | | For Examiner Use Only | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Please MARK & FILL appropriate box of problem areas. Explain below in the space provided what you understood your injury to be. Do not mark spaces to right of this section. | | Overuse | Strain | Sprain | Contusion | Concussion | Dislocation | Laceration | Fx |
| ❑ | Head | | | | | | | | |
| | Neck | | | | | | | | |
| ❑ | Back | | | | | | | | |
| ❑ | Shoulder/Arm | | | | | | | | |
| ❑ | Elbow/Forearm | | | | | | | | |
| ❑ | Wrist/Hand/Finger | | | | | | | | |
| ❑ | Hip/Thigh | | | | | | | | |
| ❑ | Knee | | | | | | | | |
| ❑ | Leg/Ankle | | | | | | | | |
| ❑ | Foot/Toe | | | | | | | | |

| | | | |
|---|---|---|---|
| 13. | Do you want to weigh more or less than you do now? | ❑ | ❑ |
| | Do you lose weight regularly to meet weight requirements for your sport? | ❑ | ❑ |
| 14. | Do you feel stressed out? | ❑ | ❑ |

15. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____

**FEMALES ONLY**

16. When was your first menstrual period? _____
When was your **most recent** menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

**Explain any INJURY here:** _____

By signing this, I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Sign on opposite page.