School Sports Pre-Participation Examination - Part 1: Student or Parent Completes

NAME: _____ **BIRTHDAY:** ____ / ____ / ____

ADDRESS: _____ **PHONE:** (____) _____

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your abi **ID#:** _____
Explain any YES answers on the back page.
Physician: Please review with the athlete details of any positive answers.

YES	NO	Don't Know	
_____	_____	_____	1. Has anyone in the athlete's family died suddenly before the age of 50 years?
_____	_____	_____	2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?
_____	_____	_____	3. Does the athlete have asthma (wheezing), hay fever, other allergies, or carry an EPI pen?
_____	_____	_____	4. Is the athlete allergic to any medications or bee stings?
_____	_____	_____	5. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
_____	_____	_____	6. Has the athlete had a head injury or concussion?
_____	_____	_____	7. Has the athlete ever had a hit or blow to the head that caused confusion, memory problems or prolonged headaches?
_____	_____	_____	8. Has the athlete ever suffered a heat-related illness (heat stroke)?
_____	_____	_____	9. Does the athlete have a chronic illness or see a physician regularly for any particular problem?
_____	_____	_____	10. Does the athlete take any prescribed medicine, herbs or nutritional supplements?
_____	_____	_____	11. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?
_____	_____	_____	12. Has the athlete ever had prior limitations from sports participation?
_____	_____	_____	13. Has athlete ever had episodes of shortness of breath, palpitations, history of reumatic fever or tiring easliy?
_____	_____	_____	14. Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?
_____	_____	_____	15. Is there a history of young people in the athlete's family who have had congenital or other heart desease: cardiomyopathy, abnormal heart rhythms, long QT or Marfan's syndrome? (You may write "I don't understand these terms" and initial this item, if appropriate).
_____	_____	_____	16. Has the athlete ever been hospitalized overnight or had surgery?
_____	_____	_____	17. Does the athlete lose weight regularly to meet the requirements for your sport?
_____	_____	_____	18. Does the athlete have anything he or she wants to discuss with the physician?
_____	_____	_____	19. Does the athlete cough, wheeze, or have trouble breathing during or after activity?
_____	_____	_____	20. Are you unhappy with your weight?
			21. FEMALES ONLY
			a. When was your first menstrual period? _____
			b. When was your most recent menstrual period? _____
			c. What was the longest time between menstrual periods in the last year? _____

Parent/Guardian's Statement:

I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give permission for my child to participate in sports / activities.

I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a licensed athletic trainer, coach, or medical practitioner.

I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment.

I hereby authorize release of these examination results to my child's school.

Signed: _____ _____
Parent/Guardian

As per ORS 336.479, Section 1(5) "Any physical examination required by this section shall be conducted by a physician possessing an unrestricted license to practice medicine, a licensed physician assistant, a certified nurse practitioner or a licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

School Sports Pre-Participation Examination - Part 2: Medical Provider Completes

NAME: _____ **ID #** _____ **Birthdate** ____/____/____

Height: _____ **Weight:** _____ **% Body Fat** _____ (Optional) **Pulse:** _____ **BP:** ___/___ (___/___, ___/___)

Vision: R 20/_____ L 20/_____ **Corrected:** Y N **Pupils:** Equal _____ Unequal _____ Regular _____ Irregular _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart: Pericardial activity			
1st & 2nd heart sounds			
Murmurs			
Pulses: brachial/femoral			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

* Station-based examination only

CLEARANCE

Cleared: _____

Cleared after completing evaluation or rehabilitation for: _____

Not Cleared: _____ Reason: _____

Provider Recommendations: _____

_____

_____

Name of Medical Provider (print/type): _____ Date: ____/____/____

Address: _____ Phone: ( )

Medical Provider's Signature: _____

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Revised May 2010