

SPORT PREPARTICIPATION HISTORY FORM

FORM CURRENTLY RECOMMENDED BY NCMS SPORTS MEDICINE COMMITTEE (7/93)

Patient's Name: _____ Age: _____
Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.
Physician's Directions: We recommend repeating the thirteen questions listed below and carefully reviewing details of any positive answers.

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

Elaborate on any positive answers:

I have answered and reviewed the questions above and give permission for my child to participate in sports.
 Signature of Parent or Guardian: _____
 Date _____ Phone # _____

EXAMINATION

PATIENT'S NAME: _____

*1. BP _____ WT _____ HT _____ Vision (R) _____ (L) _____

*2. Cardiovascular Exam _____ Normal _____ Abnormal Comments:
 Murmur _____ Yes _____ No Describe:

*3 Musculoskeletal Exam Record laxity, weakness, instability, decreased ROM-if abnormal

Knee _____ Normal _____ Abnormal
 Ankle _____ Normal _____ Abnormal
 Shoulder _____ Normal _____ Abnormal
 (Other Orthopedic _____ Normal _____ Abnormal
 Problems, e.g. neck, feet, scoliosis)

4. Optional Exam-should be done if history is positive. Comments:

ENT _____ Normal _____ Abnormal
 Chest _____ Normal _____ Abnormal
 Abdomen _____ Normal _____ Abnormal
 Genitalia _____ Normal _____ Abnormal
 Skin _____ Normal _____ Abnormal

* ASSESSMENT: 5.A. _____ No problems identified 5.B. Other

* RECOMMENDATIONS: 6.A. _____ Unlimited B. _____ Limited to specific sports C. _____ Deferred until:(e.g., rehab, recheck, consultation, lab, etc.)

* REEXAMINE: 7.A. _____ Yearly and after any injury that limits participation for greater than one week. B. _____ Other:

REQUIRED ELEMENTS ARE IN ASTERISK

I certify that I have examined the above student and that such examination revealed (_ conditions _ no conditions) that would prevent this student from participation in interscholastic sports.

Are you licensed to practice medicine in the United States _ Yes _____ No

Signature _____ Phone Number _____

Address _____ Date _____

If student not qualified, list reasons for disqualification: _____

(The following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence or one kidney, eye, testicle or ovary, etc.)