

**St. Clair County Medical Society
Pre-Participation Athletic Screening Physical**

Name: _____ Sex: Male Female Age: _____ Date of Birth: _____

Address: _____ Phone Number: (____) _____

School: _____ Grade: _____ Sport(s): _____

Personal Physician: _____

In Case of Emergency, Contact: Name: _____

Relationship: _____ Phone(H): (____) _____ (W) (____) _____

History to be completed by parent or guardian. If you answer yes to any of the questions below, please explain.

Yes | No

- Have you had a medical illness or injury since your last checkup or sports physical?
- Do you have an ongoing or chronic illness?
- Have you ever been hospitalized overnight?
- Are you currently taking any prescription or non-prescription (over the counter) medications, pills or inhalers?
- Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
- Do you have any allergies (examples: pollen, medicine, food or stinging insects)?
- Have you ever had a rash or hives develop during or after exercise?
- Have you ever passed out during or after exercise?
- Have you ever been dizzy during or after exercise?
- Have you ever had chest pain 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 the age of 50?
- Have you had a severe viral infection (example: myocarditis or mononucleosis) within the last month?
- Has a physician ever denied or restricted your participation in sports for any heart problems?
- Do you have any current skin problems? (examples: itching, rashes, acne, warts, fungus or blisters)?
- 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 become ill from exercising in the heat?
- Do you cough, wheeze or have trouble breathing during or after activity?
- Do you have seasonal allergies that require medical treatment?
- Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (example: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
- Have you had any problems with your eyes or vision?
- Have you ever had a sprain, strain or swelling after injury?

	Mo/Day/Yr of Dose	Health Provider	Date of Next Dose Due
Diphtheria-Tetanus-Pertussis DTaP/DTP/DT/Td (specify Type)	1.		
	2.		
	3.		
	4.		
	5.		
Haemophilus Influenzae Type b (Hib)	1.		
	2.		
	3.		
	4.		
Polio IPV/OPV (specify type)	1.		
	2.		
	3.		
	4.		
MMR	1.		
	2.		
Varicella	1.		
	2.		
Hepatitis B HBV	1.		
	2.		
	3.		
Pneumococcal Conjugate	1.		
	2.		
	3.		
	4.		
Other Vaccines			
Notes			

- Have you ever had a stinger, burner or pinched nerve?
- Do you have asthma?
- Do you wear glasses, contacts or protective eyewear?
- Have you broken or fractured any bones or dislocated any joints?

Explain "yes" answers here:

I give my permission that the child/student named above may participate in interscholastic athletics knowing the injuries that might occur and I consent to first aid care rendered should it be needed. I understand that the physician will not be performing a complete physical examination, and will not be liable for civil damages as a result of acts or omissions in performing the examination except for gross negligence, willful and wanton misconduct, or actions outside the scope of the physician's license. I, the parent or guardian, understand that not all life-threatening medical conditions can be detected on these pre-participation screening examinations.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian: _____

Date: _____

Pre-Participation Physical Evaluation Screening

To be completed by medical personnel

Name: _____

Birth Date: / /

Pulse: _____

BP / /

/

Medical	Normal	Abnormal Findings	Initials
Eyes/Ears/Nose/Throat			
Heart			
Lungs			
Genitalia (males only)			
MUSCULOSKELETAL			
Neck/Back			
Shoulder/Elbow			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below.

Baseball ▪ Basketball ▪ Cheerleading ▪ Cross Country ▪ Football ▪ Golf ▪ Gymnastics ▪ Ice Hockey
 Skiing ▪ Soccer ▪ Softball ▪ Swimming ▪ Tennis ▪ Track ▪ Volleyball ▪ Wrestling

Cleared _____ MD/DO
Physician Signature Date

Not Cleared For: _____

Recommendations: _____

_____ MD/DO
Physician Signature Date

Family Physician/
 Cleared _____ MD/DO
Physician Signature Date