

# PRE-PARTICIPATION ATHLETIC SCREENING FORM

School: \_\_\_\_\_ School Year: 20\_\_\_\_-20\_\_\_\_

## Part 1. Student Information (to be completed by student or parent).

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security #: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_  
 Relationship to Student: \_\_\_\_\_ Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_  
 Personal/Family Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

## Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	27. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
2. Do you have an ongoing chronic illness?	___	___	28. Do you have asthma?	___	___
3. Have you ever been hospitalized overnight?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___
4. Have you ever had surgery?	___	___	30. 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)?	___	___
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	___	___	31. Have you had any problems with your eyes or vision?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	32. Do you wear glasses, contacts, or protective eyewear?	___	___
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	___	___	33. Have you ever had a sprain, strain, or swelling after injury?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___
9. Have you ever passed out during or after exercise?	___	___	35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
10. Have you ever been dizzy during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below.</i>		
11. Have you ever had chest pain during or after exercise?	___	___	___ Head	___ Elbow	___ Hip
12. Do you get tired more quickly than your friends do during exercise?	___	___	___ Neck	___ Forearm	___ Thigh
13. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Back	___ Wrist	___ Knee
14. Have you had high blood pressure or high cholesterol?	___	___	___ Chest	___ Hand	___ Shin/Calf
15. Have you ever been told you have a heart murmur?	___	___	___ Shoulder	___ Finger	___ Ankle
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___ Upper Arm	___ Foot	
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	36. Do you want to weigh more or less than you do now?	___	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	37. Do you lose weight regularly to meet weight requirements for your sport?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___	38. Do you feel stressed out?	___	___
20. Have you ever had a head injury or concussion?	___	___	39. Record the dates of your most recent immunizations (shots) for:		
21. Have you ever been knocked out, become unconscious, or lost your memory?	___	___	Tetanus: _____ Measles: _____		
22. Have you ever had a seizure?	___	___	Hepatitis B: _____ Chickenpox: _____		
23. Do you have frequent or severe headaches?	___	___	40. Have you ever been diagnosed with measles?	___	___
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	41. Have you ever been diagnosed with mumps?	___	___
25. Have you ever had a stinger, burner, or pinched nerve?	___	___	<b>FEMALES ONLY (optional)</b>		
26. Have you ever become ill from exercising in the heat?	___	___	42. When was your first menstrual period? _____		
			43. When was your most recent menstrual period? _____		
			44. How much time do you usually have from the start of one period to the start of another? _____		
			45. How many periods have you had in the last year? _____		
			46. What was the longest time between periods in the last year? _____		

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 11.8, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**THE SCHOOL DISTRICT OF ESCAMBIA COUNTY  
PRE-PARTICIPATION ATHLETIC SCREENING**

20\_\_\_\_ -20\_\_\_\_

ECHO Needed:

Yes  No

**Part 3. Physical Examination (to be completed by physician).**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
 Visual Acuity: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b><u>MEDICAL</u></b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b><u>MUSCULOSKELETAL</u></b>			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Ann	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____
ECHOCARDIOGRAM (Optional)	_____	_____	_____

Year student-athlete received Echo: \_\_\_\_\_

\* - station-based examination only

**ASSESSMENT OF EXAMINING PHYSICIAN**

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_\_ Cleared without limitation.  
 \_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_ Referred to: \_\_\_\_\_ For: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, MD or DO

**ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)**

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_\_ Cleared without limitation.  
 \_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_, MD or DO

*Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.*