



1255 FIELD PARKWAY  
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## Upper School Pre-Participation Form

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

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Academic School: \_\_\_\_\_ Grade in School: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_  
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
1. Have you had a medical illness or injury since your last check up?	_____	_____
2. Do you have an ongoing chronic illness?	_____	_____
3. Have you ever been hospitalized overnight?	_____	_____
4. Have you ever had surgery?	_____	_____
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	_____	_____
6. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	_____	_____
7. Have you ever had a rash or hives develop during or after exercise?	_____	_____
8. Have you ever passed out during or after exercise?	_____	_____
9. Have you ever been dizzy during or after exercise?	_____	_____
10. Have you ever had chest pain during or after exercise?	_____	_____
11. Do you get tired more quickly than your friends do during exercise?	_____	_____
12. Have you ever had racing of your heart or skipped heartbeats?	_____	_____
13. Have you had high blood pressure or high cholesterol?	_____	_____
14. Have you ever been told you have a heart murmur?	_____	_____
15. Has any family member or relative died of heart problems or sudden death before age 50?	_____	_____
16. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____
17. Has a physician ever denied or restricted your participation in dance or sports for any heart problems?	_____	_____
18. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	_____	_____
19. Have you ever had a head injury or concussion?	_____	_____
20. Have you ever been knocked out, become unconscious or lost your memory?	_____	_____
21. Have you ever had a seizure?	_____	_____
22. Do you have frequent or severe headaches?	_____	_____
23. Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____
24. Have you ever had a stinger, burner or pinched nerve?	_____	_____

- |   | Yes   | No    |
|---|-------|-------|
| 25. Have you ever become ill from exercising in the heat?                                       | _____ | _____ |
| 26. Do you cough, wheeze or have trouble breathing during or after activity?                    | _____ | _____ |
| 27. Do you have asthma?   | _____ | _____ |
| 28. Do you have seasonal allergies that require medical treatment?                              | _____ | _____ |
| 29. Have you had any problems with your eyes or vision?   | _____ | _____ |
| 30. Do you wear glasses, contacts or protective eyewear?  | _____ | _____ |
| 31. Have you ever had a sprain, strain or swelling after injury?                                | _____ | _____ |
| 32. Have you broken or fractured any bones or dislocated any joints?                            | _____ | _____ |
| 33. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | _____ | _____ |

If yes, check appropriate blank and explain below:

- |               |             |               |
|---------------|-------------|---------------|
| ___ Head      | ___ Elbow   | ___ Hip       |
| ___ Neck      | ___ Forearm | ___ Thigh     |
| ___ Back      | ___ Wrist   | ___ Knee      |
| ___ Chest     | ___ Hand    | ___ Shin/Calf |
| ___ Shoulder  | ___ Finger  | ___ Ankle     |
| ___ Upper Arm | ___ Foot    |               |

- |   |       |       |
|---|-------|-------|
| 34. Do you want to weigh more or less than you do now?              | _____ | _____ |
| 35. Do you try to lose weight regularly ?                           | _____ | _____ |
| 36. Do you often feel stressed out?                                 | _____ | _____ |
| 37. Record the dates of your most recent immunizations (shots) for: |       |       |
| Tetanus: _____ Measles: _____                                       |       |       |
| Hepatitis B: _____ Chickenpox: _____                                |       |       |

**FEMALES ONLY**

38. When was your first menstrual period? \_\_\_\_\_
40. How many periods have you had in the last year? \_\_\_\_\_

Explain "Yes" answers here:

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

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

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

**Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).**

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>MEDICAL</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	_____	_____	_____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MUSCULOSKELETAL			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____

\* – station-based examination only

**ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER**

I hereby certify that each examination listed above was performed by me 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/Physician Assistant/Nurse Practitioner (print): \_\_\_\_\_  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 Address: \_\_\_\_\_

Signature of Physician/Physician Assistant/Nurse Practitioner: \_\_\_\_\_

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

I hereby certify that the examination(s) for which referred was/were performed by me 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): \_\_\_\_\_  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

*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.*