CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM

This form MUST be completed for every sports participant with parent/guardian & athlete signatures

Student's Name _____ Sex M F Age ____ Date of Birth _____

Address _____ Student ID #_____

Grade _____ School _____ Sport(s) _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain **"YES"** answers below. Circle questions you do not know the answers to.

	YES	NO
1. Do you have any major health conditions?	☐	☐
2. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
3. Have you ever been hospitalized overnight?	☐	☐
4. Have you ever had surgery?	☐	☐
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	☐	☐
a. Have you ever taken any supplements, steroids, or vitamins, protein, creatine to help you gain or lose weight or improve your performance?	☐	☐
6. Do you have any allergies (for example: medication, food, stinging insects or pollen)?	☐	☐
7. Have you ever passed out during or after exercise?	☐	☐
a. Have you ever been dizzy during or after exercise?	☐	☐
b. Have you ever had chest pain during or after exercise?	☐	☐
c. Do you get tired more quickly than your friends do during exercise?	☐	☐
d. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
e. Have you had high blood pressure or high cholesterol?	☐	☐
f. Have you ever been told you have a heart murmur?	☐	☐
g. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
h. Have you had a severe viral infection (for example: infection in the heart or mononucleosis) within the last six months?	☐	☐
i. Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
8. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?	☐	☐
9. Have you ever had a head injury or concussion?	☐	☐
a. Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
b. Have you ever had a seizure?	☐	☐
c. Do you have frequent or severe headaches?	☐	☐
d. Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
e. Have you ever had a stinger, burner or pinched nerve?	☐	☐
10. Have you ever become ill from exercising in the heat?	☐	☐

11. Do you cough, wheeze or have trouble breathing during or after activity? **Yes** ☐ **No** ☐
    a. Do you have asthma or use an inhaler? **Yes** ☐ **No** ☐
    b. Do you carry your inhaler while you are playing sports? **Yes** ☐ **No** ☐
12. Do you have Diabetes **Yes** ☐ **No** ☐
    If so, do you take insulin? **Yes** ☐ **No** ☐
13. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? **Yes** ☐ **No** ☐
14. Have you ever had a sprain, strain or swelling after injury, or any other problem with pain or swelling in muscles, tendons, bones or joints? **Yes** ☐ **No** ☐
    If yes, check appropriate box, indicate R for right and L for left, and explain below:

Head	☐	Elbow	☐	Hip	☐
Neck	☐	Forearm	☐	Thigh	☐
Back	☐	Wrist	☐	Knee	☐
Chest	☐	Hand	☐	Shin	☐
Shoulder	☐	Finger	☐	Calf	☐
Arm	☐	Ankle	☐	Foot	☐

15. Have you had any problems with your eyes or vision, wear glasses, contact lenses or protective eyewear? **Yes** ☐ **No** ☐
16. **For females**, age at first period _____
    Are periods regular? **Yes** ☐ **No** ☐
17. When was your last tetanus shot?
    Tdap (date) _____
18. Explain **"YES"** answers here: _____

_____
_____
_____
_____
_____
_____
_____

I hereby state that to the best of my knowledge, my answers to all the above questions are correct and complete and I take full responsibility for any incorrect answers

Signature of Athlete _____ **Signature of Parent/Guardian** _____ **Date** _____

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Student's Name _____ **Sex M or F** **Date of Birth** _____

Height: _____ **Weight:** _____ **BMI:** _____ **Pulse:** _____ **BP:** _____/_____ **Hgb:** _____

Vision: Grossly Intact _____ **Corrected: Y or N** **Pupils: Equal** ____ **Unequal** ____

Physical Screening	Normal Findings	X	Abnormal Findings	No Exam
Appearance	WDWN			
Eyes/Ears/Nose/Throat	WNL			
Lymph Nodes	WNL			
Hearing	Grossly Intact			
Heart	RRR, No Significant Murmur			
Pulses	WNL			
Lungs	Clear/equal			
Abdomen	Soft, No HSMT			
Skin	Warm/Dry/Intact			
Neck	FROM			
Back	No Scoliosis			
Shoulder/Arm/Elbow	FROM, = strength			
Forearm/Wrist/Hand	FROM, = grip/strength			
Hip/Thigh/Knee	FROM			
Leg/Ankle/Foot	FROM			
Hernia/Squat/Duck Walk	WNL			
Immunizations given				

CLEARANCE

☐ Cleared

☐ **NOT** Cleared until completed evaluation/rehabilitation for: _____

_____

_____

_____

☐ Not cleared for: _____ Reason: _____

☐ Recommendations: _____

_____

_____

_____

_____

Name of Health Care Provider (print/type/stamp): _____ Date of exam: _____

Address: _____ Phone: _____

Signature of Health Care Provider: _____Date of signature: _____

This form was developed based upon guidelines from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Academy of Sports Medicine, 2009.

Rev: 05/10/2013