PREPARTICIPATION HISTORY FORM

(DIRECTIONS: This form should be filled out by patient and guardian prior to seeing medical provider. Return to school for record/documentation.)

Name: _____ Exam Date: _____

Birth Date: _____ Gender: ◯ Female ◯ Male Sport(s): _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? ◯ Yes ◯ No If yes, please identify (circle) and list specific allergy below.

Medicines Pollens Foods Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ High cholesterol ☐ Kawasaki disease ☐ A heart murmur ☐ A heart infection ☐ Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	**YES**	**NO**
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		
Explain "yes" answers on back page:		

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

Signature of Athlete: _____ Date: _____

Signature of Guardian: _____ Date: _____

PHYSICAL FORM – EXAMINATION FORM

DIRECTIONS: This form must be completed by medical provider.* Return form following appointment for school record/documentation.

Name: _____ Exam Date: _____

Birth Date: _____ Gender: ◯ Female ◯ Male Sport(s): _____

MEDICAL PROVIDER REMINDERS

1. Consider additional questions on more sensitive issues

• Do you feel stressed out or under a lot of pressure? • Do you ever feel sad, hopeless, depressed, or anxious? • Do you feel safe at your home or residence? • Do you or have you drank alcohol or used marijuana, tobacco or any other drugs during the past 30 days? • Have you ever taken anabolic steroids or used any other performance supplement? • Have you ever taken any supplements to help you gain or lose weight or improve your performance?

2. Consider reviewing "Yes" questions from History Form.

EXAMINATION			
Height	Weight	Pulse	
BP / (/)	Vision R 20/ L 20/	Corrected: ◯ Yes ◯ No	
MEDICAL		**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/Ears/Nose/Throat • Pupils equal • Hearing			
Lymph nodes			
Heart [A] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)[B]			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic [C]			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	MUSCULOSKELETAL (Continued)	NORMAL	ABNORMAL FINDINGS
Neck			Hip/Thigh		
Back			Knee		
Shoulder/Arm			Leg/Ankle		
Elbow/Forearm			Foot/Toes		
Wrist/Hand/Fingers			Functional • Duck-walk, single leg hop		

[A] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [B] Consider GU exam if in private setting. Having third party present is recommended. [C] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared with restrictions **OR** Not cleared for participation

•If restrictions are required or student-athlete is not cleared, complete attached form to document detailed restrictions and/or clearance guidelines.

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the guardian. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Medical Provider (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Medical Provider _____, *MD, DO, PA, ARNP, ND

* Per WIAA, approved medical providers licensed to perform this exam include a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA), and Naturopathic Physician (ND).

RESTRICTIONS FORM

(DIRECTIONS: If student-athlete is not fully cleared to participate, or if clearance to participate is contingent upon activity restrictions or modifications, completion of this form is required in addition to the Physical and History Forms. Form must be completed by medical provider* for injured athlete to participate in sport(s). Return form to school record/documentation.)

Name: _____ Exam Date: _____

Birth Date: _____ Gender: ◯ Female ◯ Male Sport(s): _____

◯ Cleared for all sports with the following restrictions:

◯ Not cleared

◯ Pending further evaluation ◯ For any sports ◯ For certain sports: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the guardian. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Medical Provider (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Medical Provider _____, *MD, DO, PA, ARNP, ND

ATHLETE/GUARDIAN REMINDER

Please return the following form to school. Copies can be made at school-site for the following:

Athletic Secretary/Athletic Director School Nurse School Athletic Trainer

* Per WIAA, approved medical providers licensed to perform this exam include a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA), and Naturopathic Physician (ND).