

Pre-Participation Physical Exam/Medical History Form (2017-2018)

First Baptist Academy (Powell, TN)

Athlete's Name _____

DOB _____ / _____ / _____

Examination		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____	Pulse _____	Vision: Right 20/____ Left 20/____ Corrected <input type="checkbox"/> yes <input type="checkbox"/> 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 • Murmurs (auscultation standing, supine, +/-Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

- Cleared for all sports without restriction.
- Cleared for all sports without restriction with recommendation for further evaluation/treatment for: _____

- Not cleared:
 - Pending further evaluation
 - For any sports
 - For certain sports _____

Reason _____

Recommendation(s) _____

I have examined the above-named student and completed the pre-participation 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 parents. 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 physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____ MD/DO

(Physician to complete & sign one copy for student athlete to return to FBA.)

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(Student athlete & parent/guardian to complete this info prior to exam; physician to keep a copy in the chart & provide one copy to be returned to FBA).

Athlete's Name: (print)	DOB:	Grade:	<input type="checkbox"/> Male
			<input type="checkbox"/> Female

Please explain "yes" answers below.

Please explain "yes" answers below.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other:			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other:			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			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?		
BONE & JOINT QUESTIONS	Yes	No	51. Do you have any concerns that you would like to discuss with a doctor?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			FEMALES ONLY	Yes	No
18. Have you ever had any broken or fractured bones or dislocated joints?			52. Have you ever had a menstrual period?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			53. How old were you when you had your first menstrual period?		
20. Have you ever had a stress fracture?			54. How many periods have you had in the last 12 months?		
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)			Explain "yes" answers here:		
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?					

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I give permission for First Baptist Academy to receive copies of this Pre-Participation Physical Exam/Medical History Form for their records.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____